

# **COMPILATION OF STATISTICAL SOURCES ON ADULT DISABILITY**

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# COMPILATION OF STATISTICAL SOURCES ON ADULT DISABILITY

Human Services Research Institute  
2336 Massachusetts Avenue  
Cambridge, MA 02140

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Research Library  
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Prepared under contract to the  
National Institute on Disability and Rehabilitation Research  
U.S. Department of Education  
Washington, DC

**1986**

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## INTRODUCTION

This document is designed to serve as a reference for researchers, administrators and practitioners looking for national statistical information on adult impairments. It contains profiles of major national data files for points or periods of time since January 1978 (and some earlier files as well) which contain statistics on adults eighteen years or older who have physical, mental, or emotional impairments that impede life functions.

Thirty data files were selected for inclusion in this inventory. Some of these files contain two or more related surveys.

The data files are described according to a standard format presented on the following pages. Headers and subheaders are listed with explanations where necessary to clarify the type of information contained under each.



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# INVENTORY FORMAT

## CONTACT

Name of person(s) most familiar with the intellectual content and structure of the data file. The mailing address for each contact is listed.

## SPONSOR

Name of agency(ies) responsible for financing/administering the survey(s) or information system.

## PERIOD

Month, months, or season and years for which data were collected. In the case of periodic or continual surveys, the earliest and latest periods are noted.

## SURVEY DESCRIPTION

### Survey Objectives

Purpose(s) which the survey is intended to serve.

### Population Surveyed

Segments of the U.S. population surveyed.

### Survey Size

Number of units (e.g., persons, families, households, organizations, etc.) identified for survey. In the case of a sample survey, the number of units in the universe from which the sample is drawn, as well as the number of the units in the sample, is indicated.

### Survey Design

In the case of population censuses or surveys of an entire universe of agencies, the source(s) of information

and/or procedures used to identify the entire universe of responding units are described. In the case of sample surveys, the sampling scheme is described.

### Data Source

Method used to collect the data (e.g., telephone survey, mail questionnaire).

### Estimation (Case Weighting) Scheme

Applicable to sample surveys only. Brief description of how sample cases are weighted in order to minimize the variance associated with sample estimates. Cases are always weighted by the probability of the case's selection as part of the sample, most always adjusted for non-response, and in the case of complex multiple-stage probability samples, ratio-adjusted to independent estimates of the probability of the case's selection (in order to make the sample more closely representative of the universe).

### Response Rates

Number and percent of survey units responding and/or not responding, with explanation where needed to clarify the reasons for and significance of the nonresponse.

### Treatment of Missing Values

A brief explanation of how missing responses to survey items (if any) are shown in the results, and the method(s) used, if any, to substitute imputed values for missing responses.

### Sampling Error

Applicable to sample surveys only. Indicators of the sampling error of estimates of the size of the impaired

adult population. The most meaningful indicators obtainable are reported.

The indicators show either: (1) the standard error or relative standard error of estimates or (2) number of persons in the sample identified as impaired and/or disabled.

## KEY VARIABLES AND VARIABLE BREAKDOWNS

### Age

Shows the range and age intervals coded.

### Race/Ethnicity

Shows the range of responses possible.

### Family Income

Shows the income intervals coded.

### Employment Status

Indicates whether the person's employment status is shown.

### Rural/Urban Residence

Shows the range of responses possible.

### Disabling Conditions/Functional Limitations

Lists the questions used in describing disabling conditions and related limitations in functional performance, and in describing the duration, past or projected, of these conditions and activity limitations. Identifies established classification systems (e.g., *International Classification of Diseases*, Ninth Revision), if any, used in classifying disabling conditions or associated limitations in functioning.

### Family Composition

Indicates the descriptors used to indicate the make-up of the family of surveyed adults.

## Beneficiary Status for Major Federal Programs

Indicates any major programs from which the respondent derives income.

## Other Health Related Data

Indicates whether or not information is reported relating to the respondent's health other than that used to establish the respondent's impairment or that relating to the respondent's utilization of health services.

## Service Utilization

Indicates the types of services for which use information is provided and whether the frequency or level of use is reported.

## AVAILABILITY OF DATA

Indicates whether data or tapes are available for public use.

## Price of Data or Tapes

Indicates the price of user tapes or data compilations and related documentation.

## User Representative

Provides the names and addresses of persons with whom one may discuss the prices and characteristics of the tapes or data. Unless a separate location is identified as the "order point," the user representative's address is also the place where one can order the tapes and related documentation.

## TAPE CHARACTERISTICS

### Density

Measured in bytes per inch (e.g., 800, 1600, 6250).

### Number of Tracks

Seven or nine.

### Magnetic Recording Codes

American Standard Code for Information Interchange (ASCII) and/or extended binary coded data interchange (EBCDIC).

### Preformatted

Indicates if the tape has been preformatted for use with SPSS, SAS, BMD, or other statistical packages.

### Data Structure

Indicates whether the file data are organized in rectangular, hierarchical, or inverted fashion. Rectangular files contain records referring to observations and columns referring to variables. Hierarchical files are often found when one processes data on households. In these files, the number of data records for individual households varies because the number of persons in each household varies. In the case of inverted file structures, data records refer to variables, and columns refer to observations of each unit of analysis.

### Technical Documentation

References to technical documents.

## SURVEY EVALUATION

### Narrative Assessment

This section briefly discusses the survey limitations in terms of generating statistics relating to adults with disabilities. Noted are any methodological weaknesses as identified in the technical documentation and survey instruments, in discussions with agency personnel, and from knowledge of prior users. These limitations may relate to any of the following:

Sample bias, the over or under-representation of some segment of the handicapped adult population.

Sampling error so large that it prohibits use of the data file to generate reasonably accurate estimates.

Non-sampling error, which refers to unusually high occurrence of various response errors and operational errors in the data collection, responses, coding, and transcription that combine to reduce one's confidence in the accuracy of the data.

Nonresponse to the survey or to particular items in the survey which is notably large or systematic for reasons unknown.

Variable definitions, which occur when variables are not clearly defined or are defined in such a way that their utility for comparative or longitudinal analyses is restricted.

Analytical limitations associated with the file data structures and/or with the level of source data aggregation.

### Prior Users and Use Reports

Selected references to published analytic reports reflecting prior uses of the data file.

# ANNUAL CENSUS OF ADDITIONS AND RESIDENT PATIENTS IN STATE AND COUNTY MENTAL HOSPITALS

## CONTACT

Ronald W. Manderscheid, Ph.D  
Chief  
Survey and Reports Branch  
Division of Biometry and Applied Sciences  
National Institute of Mental Health  
Room 18-C-07  
5600 Fishers Lane  
Rockville, MD 20857  
(301) 443-3343

## SPONSOR

National Institute of Mental Health (NIMH).

## PERIOD

Annually, since 1950; latest year, 1983.

## SURVEY DESCRIPTION

### Survey Objectives

To describe the utilization patterns of state and county mental hospitals.

### Population Surveyed

State mental health agencies and in some cases individual hospitals report the number of persons admitted to (additions) and resident in state and county mental hospitals.

## Survey Size

280 facilities.

## Survey Design

The list of state and county mental hospitals to be included in the Census is continually updated in consultation with state and county mental health authorities.

## Data Source

By agreement with state and territorial mental health authorities, 36 states complete the census form for the hospitals. Hospitals in the other 14 states and four territories complete the forms themselves.

## Estimation (Case Weighting) Scheme

Not applicable.

## Response Rates

227 facilities or 82.2 percent responding to the "additions" part of the survey.

212 facilities or 76.8 percent responding to the "resident" part of the survey.

## Treatment of Missing Values

Imputed from responses of like facilities, matched first in terms of size, and then by region and area of the country.

## Sampling Error

Not applicable.



## KEY VARIABLES AND VARIABLE BREAKDOWNS

### Age

Under 18 yrs, 18-24, 25-44, 45-64, 65 and over.

### Race/Ethnicity

Not reported.

### Family Income

Not reported.

### Employment Status

Not reported.

### Rural/Urban Residence

Not reported.

### Disabling Conditions/Functional Limitations

Fourteen or sixteen diagnostic groups (depending upon the year) are coded based on diagnoses from the *International Classification of Diseases* or the *Diagnostic and Statistical Manual*: mental retardation, alcohol related, organic disorders, affective disorders, schizophrenia related, other psychotic, anxiety/somatic disorders, personality disorders, pre-adult disorders, other nonpsychotic, social, no mental disorder, deferred/undiagnosed.

### Family Composition

Not reported.

### Beneficiary Status for Major Federal Programs

Not reported.

### Other Health Related Data

Not reported.

### Other Demographic Data

Sex.

### Geographical Area

State:

Reported.

Region:

Ten Census regions reported.

SMSA:

Not reported.

### Service Utilization

Not reported (beyond the assumption that all additions and residents are using hospital services).

## AVAILABILITY OF DATA

Tapes available for the years 1970 to 1983.

### Price of Tapes

Available free of charge; however, a blank tape must be provided.

### User Representative

Ronald W. Manderscheid, Ph.D  
Chief  
Survey and Reports Branch  
Division of Biometry and Applied Sciences

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Rockville, MD 20857  
(301) 443-3343

The data are reported in aggregate form thus precluding the cross tabulation of admission/resident characteristics.

## Prior Users and Use Reports

*Additions and Resident Patients at the End of Year in State and County Hospitals by Age, Diagnosis, and State, U.S., 1981.* National Institute of Mental Health, Division of Biometry and Applied Sciences, Survey and Reports Branch, 1984.

Taube, C. and Barrett, S. (eds). *Mental Health, United States 1983.* National Institute of Mental Health, 1983.

## TAPE CHARACTERISTICS

### Density

6250 bpi.

### Number of Tracks

Nine.

### Magnetic Recording Codes

EBCDIC.

### Preformatted

SAS.

### Data Structure

Rectangular.

### Technical Documentation

Unpublished documents available on request.

## SURVEY EVALUATION

### Narrative Assessment

Includes only those persons admitted to state and county mental hospitals.

It must be assumed that the person's admission to or residence in a state or county mental hospital indicates that his or her mental illness is disabling.



# CASE SERVICE REPORT (RSA 300/911): STATE-FEDERAL PROGRAM OF VOCATIONAL REHABILITATION

## CONTACT

Larry Mars  
Rehabilitation Services Administration  
330 C Street, SW  
Room 3033A  
Washington, DC 20202  
(202) 732-1404

## SPONSOR

Rehabilitation Services Administration  
Office of Special Education and Rehabilitative Services  
U.S. Department of Education

## PERIOD

Tapes or punchcards are submitted annually by each state rehabilitation agency. Files are available back to the early 1970's.

## SURVEY DESCRIPTION

### Survey Objectives

The Case Service Report provides information on the demographic and economic characteristics of clients whose cases are terminated each year as well as program variables such as cost and types of services provided. The data are used to gauge the effectiveness of the rehabilitation program and to provide information for budgetary, legislative and administrative purposes. The data provide the basis for cost/benefit studies. The core data in the *Case Service Report* are required by law under Section 13 of the Rehabilitation Act.

## Population Surveyed

All persons with case closures from state vocational rehabilitation (VR) systems, either rehabilitated, not rehabilitated or not accepted for services.

## Survey Size

Approximately 600,000 cases are closed out each year (595,274 in Fiscal Year 1985).

## Survey Design

This is not a survey. All state vocational rehabilitation agencies are to submit information on all case closures to the Rehabilitation Services Administration (RSA) each year. This involves a few dozen items of information on each client whose case is terminated.

## Data Source

The Case Service Report represents a portion of the client data available in each state VR agency. Agencies are located in each of the 50 states, the District of Columbia, and all outlying territories. Some states have separate agencies for blind and visually impaired persons.

## Estimation (Case Weighting) Scheme

Not applicable.

## Response Rates

In typical years, approximately 95 percent of all expected records are received and tabulated. Occasionally, an agency with computer problems cannot report. Also, some records from reporting agencies may be eliminated because they could not pass the computer edit.

## Treatment of Missing Values

Generally, there is no special treatment of missing values. Occasionally, a value missing from one data element can

be imputed logically from another data element. In these instances, the computer will assign a code. If large numbers of values for critical data elements are not reported, a state agency may be asked to resubmit another tape.

### Sampling Error

Not applicable.

## KEY VARIABLES AND VARIABLE BREAKDOWNS

### Age

Ages can be classified and tabulated in any manner.

### Race/Ethnicity

White, Black, American Indian/Alaskan Native, Asian and Pacific Islander.

Persons of Hispanic origin, persons not of Hispanic origin.

### Family Income

This is a coded item in the RSA-300 system. It will not, however, be continued with the RSA-911 system in Fiscal Year 1987. The income groups are broken out as follows: Less than \$150 monthly income, \$150-199, \$200-249, \$250-299, \$300-349, \$350-399, \$400-449, \$450-499, \$500-599, \$600 and over.

### Employment Status

This is reported in the form of weekly earnings and work status (e.g., competitive employment) at the time of application and case closure.

### Rural/Urban Residence

Not reported.

## Disabling Conditions/Functional Limitations

Major and secondary disabling conditions: There are 170 three-digit codes to identify the major and secondary disabling conditions of clients. These can be tabulated in any manner. Examples of groupings are as follows:

Blindness, other visual impairments, deafness, hard of hearing, orthopedic impairments, absence or amputation of extremities, mental illness, alcoholism, drug addiction, mental retardation, hay fever and asthma, diabetes mellitus, epilepsy, other nervous system conditions, heart disease, varicose veins/hemorrhoids, other circulatory conditions, respiratory system conditions, digestive system conditions, end-stage renal failure, other genitourinary conditions, speech impairments, skin conditions, specific developmental disorders (learning disabilities), and other conditions.

The primary cause of visual, hearing and orthopedic impairments and the absence or amputation of extremities are also identified. They include:

Cerebral palsy, other congenital conditions, arthritis and rheumatism, stroke, poliomyelitis, muscular dystrophy, multiple sclerosis, Parkinson's disease, accidents involving the spinal cord, all other accidents and injuries, malignant neoplasms, cataracts, glaucoma and other diseases.

Severely disabled status: Severely disabled, not severely disabled.

### Family Composition

Number of dependents, number in family. These RSA-300 items will be not continued in the RSA-911 system in Fiscal Year 1987.

### Beneficiary Status for Major Federal Programs

It is indicated whether the client was receiving any of the following types of public support: Social Security Disability Income, Supplemental Security Income, or Aid to Families with Dependent Children.

## Other Health Related Data

Not reported.

## Other Demographic Data

Sex, marital status, education.

## Geographical Area

Characteristics data are tabulated for all states, the District of Columbia, the outlying territories, and by ten Federal regions.

## Service Utilization

### Types of Services

Diagnoses and evaluation; restoration (physical or mental); training of various kinds such as college/university, vocational or trade school, on-the-job, personal and vocational adjustment; maintenance; and other services to clients.

### Level of Utilization

Reported as cost data.

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## SURVEY EVALUATION

### Narrative Assessment

The Case Service Report provides a rich assortment of information on clients completing the rehabilitation process, successfully or not. The data are used to assess the impact of services on a variety of target groups within the disabled population. The data provide limited information on functional limitations.

### Prior Users and Use Reports

A report on client characteristics is published annually by which time tabulations of data for more recent years are usually available. At this writing, for example, data for Fiscal Year 1984 have been tabulated even though the last published report, cited below, displays data only through Fiscal Year 1982.

*Characteristics of Persons Rehabilitated and Reasons for Case Closure in Fiscal Year 1982 (RSA-IM-85-37).* Rehabilitation Services Administration, Office of Program Operations, September 1985.

## AVAILABILITY OF DATA

Data are available in the form of published reports, raw tabulations and computer tapes.

### Price of Data or Tapes

They are free of charge. Requests for tapes, however, must be justified in writing in a letter to the Commissioner, RSA.

### User Representative

Larry Mars  
Rehabilitation Services Administration

# CENSUS OF POPULATION (1980)

## CONTACT

Paula Schneider  
Population Division  
Bureau of the Census  
U.S. Department of Commerce  
Washington, DC 20233  
(301) 763-7962

Disability information:

Jack McNeil  
Population Division  
Bureau of the Census  
U.S. Department of Commerce  
Washington, DC 20233  
(301) 763-7946

## SPONSOR

Bureau of the Census.

## PERIOD

Decennial. (The following information is based on the 1980 Census).

## SURVEY DESCRIPTION

### Survey Objectives

To obtain information about the demographic characteristics of the U.S. population.

### Population Surveyed

Occupants of all housing units and group quarters.

(Note: The group quarters data are reported as a separate file, *Census of Persons in Institutions and Other Group Quarters*.)

## Survey Size

Approximately 19 percent of all housing units receive the long form questionnaire (see "Survey Design") containing questions on disability status.

## Survey Design

Every housing unit is included in the Census; however a sample receives the long form questionnaire that contains more extensive information from which estimates of disability may be derived.

The basic sampling unit is the housing unit, including all occupants. In counties, incorporated places, and minor civil divisions estimated to have fewer than 2,500 persons (based on pre-census estimates), one half of all housing units are included in the sample. In other places, one sixth of the housing units are sampled. Taking both sampling rates into account, approximately 19 percent of the nation's housing units are included in the census 1980 sample.

Summary data of Census items for a variety of geographical areas are available on summary tape files. Also available are three separate public use microdata subsamples that allow users to cross tabulate items. These are designated "A," "B" and "C." Each features a different geographic scheme. The largest of the three is the "A" sample, which includes 5 percent of all U.S. households and over one-fourth of the households receiving the census long form questionnaire. It identifies every State and almost all individual counties with 100,000 or more inhabitants.

## Data Source

By and large the census is completed through self-enumeration. Missing data are followed up with telephone or in-person interviews. In about 95 percent of the country the census is sent through the mail. In the other 5 percent of the country it is distributed and collected by census enumerators.

## Estimation (Case Weighting) Scheme

An iterative ratio estimation procedure is used to assign a weight to each sample person or housing unit record. This procedure is performed within geographically defined "weighting areas" (i.e., adjoining portions of geography containing a sample of at least 400).

For persons, the weighting procedure occurs in three stages:

- (1) Type of household (17 types)
- (2) Householder/Nonhouseholder
- (3) Age/Sex/Race/Spanish Origin

For occupied housing units, the procedure occurs in two stages:

- (1) Type of household (16 types)
- (2) Tenure/Race/Spanish Origin/Value-Rent (190 categories)

For vacant housing units the procedure occurs in one stage:

- (1) Vacant for rent/vacant for sale/other vacant

Microdata samples are self-weighting; users simply multiply by the inverse of the sampling rate.

## Response Rates

Response rate information is not available separately for the long versus short form census questionnaire. Due to extensive followup and allocation procedures, only 1.2 percent of households and persons in institutions or other group quarters failed to respond at all to the 1980 Census. For these cases, the entire questionnaire is imputed. In the remaining 98.8 percent of the cases at least some information is obtained, providing a basis for allocating values to any missing items (see "Treatment of Missing Values" below).

## Treatment of Missing Values

The number of missing values is greatly minimized through extensive followup procedures. Missing values are replaced by entries based on information reported for another person or housing unit with related characteristics.

## Sampling Error

Unadjusted standard error tables for published number and percentage estimates are available, along with instructions for calculating standard errors of differences, means, and medians. Estimates of the number of noninstitutionalized persons with disabilities are:

12,319,551 persons 16-64 years of age with a work disability (standard error = 8,258);

2,597,631 persons 16-64 years of age with a public transportation disability (standard error = 3,928);

3,588,536 persons over age 64 with a public transportation disability (standard error = 4,298).

## KEY VARIABLES AND VARIABLE BREAKDOWNS\*

### Age

Age in years up to 90.

### Race/Ethnicity

White; Black; American Indian, Eskimo or Aleutian; Asian or Pacific Islander (8 categories, e.g., Japanese, Chinese, Korean, etc.); other; Spanish write-in entry.

Spanish origin and ancestry also are coded.

---

\*Reported as coded for public use microdata samples.



## Family Income

Income for each individual is recorded to the nearest dollar, up to \$75,000.

## Employment Status

Reported.

## Rural/Urban Residence

Central city of SMSA (selected SMSA's on A or B sample); in SMSA, outside of central city (selected SMSA's on A or B sample); SMSA, central city/remainder not separately identified (separately identified selected SMSA's on A sample); mixed SMSA/non-SMSA area (A sample only); outside SMSA's (C sample only); central city of urbanized area (C sample only); urban fringe (C sample only); other urban (C sample only); rural (C sample only).

## Disabling Conditions/Functional Limitations

Does this person have a physical, mental, or other health condition which has lasted for six or more months and which:

- (1) Limits the kind or amount of work this person can do?
- (2) Prevents this person from working at a job?
- (3) Limits or prevents this person from using public transportation?

## Family Composition

Household Type: Married-couple family household; family household with male householder, no wife present; family household with female householder, no husband present; nonfamily household.

Presence and Age of Own Children: Family with own children under 6 years only; family with own children 6-17 years only; family with own children, some 6 to 17 years and some under 6 years; family without own children.

Relationship to Householder: Spouse; child; brother or sister; parent; other relative (9 categories); person not related to householder (4 categories); in group quarters (inmate/noninmate).

Subfamily Relationship: Husband-wife in married-couple subfamily; parent in parent-child subfamily; child in subfamily.

## Beneficiary Status for Major Federal Programs

Social Security, public assistance, Supplemental Security Income, Aid to Families with Dependent Children.

## Geographical Area

State:

Reported.

Region:

Not reported.\*

SMSA:

Reported.

## Service Utilization

Not reported.

## AVAILABILITY OF DATA

### Price of Tapes

A five percent sample, with county-based information, is available:

1600 bpi (90 tapes): \$12,600.

6250 bpi (23 tapes): \$3,220.

\*Estimates of disability may be obtained from the Summary Tape Files for regions and a variety of other geographical areas.

One percent and one in 1,000 tapes are also available.

### **User Representative**

Data User Services Division  
Customer Services  
Bureau of the Census  
Washington, DC 20233  
(301) 763-4100

## **TAPE CHARACTERISTICS**

### **Density**

1600 or 6250 bpi.

### **Number of Tracks**

Nine.

### **Magnetic Recording Codes**

EBCDIC or ASCII.

### **Preformatted**

No.

### **Data Structure**

Hierarchical.

## **Technical Documentation**

Zeisset, Paul T. *Public-Use Microdata Samples from the 1980 Census*. Bureau of the Census, January 1983.

*Census of Population and Housing: Public-Use Microdata Samples Technical Documentation*. Bureau of the Census.

## **SURVEY EVALUATION**

### **Narrative**

Though the design and implementation of the Census household survey is thorough, information on disability is limited. Only estimates and characteristics of persons with work and transportation disabilities can be derived, with no data on types or duration of disability.

### **Prior Use and Users Reports**

*Characteristics of the Population of 1980 Census of Population, 1. General Social and Economic Characteristics. Chapter C, Series PC80-1-C*. Bureau of the Census, Spring/Fall 1980.

*Selected Characteristics of Persons with a Work Disability by State: 1980*. Supplementary Report, Series PC80-S1-20. Bureau of the Census, November 1985.

# CONTINUOUS DISABILITY HISTORY SAMPLE (CDHS)

## CONTACT

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Division of Disability Studies  
Office of Research and Statistics  
Social Security Administration  
6401 Security Boulevard  
Baltimore, MD 21235  
(301) 594-0721

## SPONSOR

Social Security Administration.

## PERIOD

Annually since 1957.

## SURVEY DESCRIPTION

### Survey Objectives

To support special studies of the disability applicant population.

### Population Surveyed

Persons applying for disability benefits under the Social Security Disability Insurance (SSDI) Program (Title II) and for whom eligibility determinations have been made.

To qualify for disability benefits, a person must have been disabled for at least five consecutive months, must be unable to engage in any substantial gainful activity, and have a disability that can be expected to result in death or to last for a continuous period of not less than 12 months; or be statutorily blind within the meaning of the law (central vision acuity of 20/200 or less in the better eye with correction lens).

Beneficiaries include: (1) disabled workers under age 65 and (a) dependent children under age 18, (b) wife, if she has eligible dependent children in her care, and (c) dependent spouse age 62 or over; (2) adults disabled in childhood (before age 22) who are dependent children of entitled, insured or deceased workers; and (3) disabled widows or widowers, and disabled divorced wives.

Disabled workers must be fully insured with at least 20 quarters of coverage in the last 40 quarter period ending with the quarter in which the worker became disabled. A worker disabled before the quarter in which he/she attains age 31 is insured for disability if the person has covered employment in one-half of the quarters between attainment of age 21 and onset of disability. A worker disabled before the quarter in which the worker attains age 24 is insured for disability if he/she has six quarters of coverage in the 12 quarter period before onset of disability. A worker disabled for blindness needs only fully insured status.

### Survey Size

37,621 cases sampled in 1978.

### Survey Design

The Continuous Disability History Sample file contains longitudinal beneficiary and earnings data to support special studies of the disability applicant population. New applicants for disability insurance (SSDI) benefits meeting the eligibility criteria are added to the file each year at the time claims are processed, and each file is annually updated. A sample case is retained in the CDHS master file until termination of disability benefits or death.

The annual sample of disabled beneficiaries records is drawn randomly, with the samples of disabled workers allowed benefits during the calendar year stratified by state at a sampling rate from 10 to 100 percent depending on the number of allowances in each state for the preceeding year. The sample rate decreases as the total number of workers in each state increases.



## Data Source

Disabled beneficiary records.

## Estimation (Case Weighting) Scheme

Cases have two weights: (1) basic weights which are the reciprocals of the probabilities of case selection and (2) ratio adjustment weights to make the estimated totals agree with previously published award totals in each state.

## Response Rates

Not applicable.

## Treatment of Missing Values

Missing values are shown as such.

## Sampling Error

Standard error tables for the United States and by state are provided with published statistics. Standard errors for estimated numbers of workers with disability claims in the United States: Estimate 100 (standard error 25); estimate 100,000 (standard error 765).

## KEY VARIABLES AND VARIABLE BREAKDOWNS

### Age

Age in years up to 99.

### Race/Ethnicity

White, Black, other.

### Family Income

Dollars earned during first year worked, last year worked, and current year.

## Employment Status

Reported (all beneficiaries are unemployed).

## Rural/Urban Residence

Could be imputed using the county or zipcode of residence together with supplementary information classifying the counties or zipcode areas as urban or rural.

## Disabling Conditions/Functional Limitations

SSDI beneficiaries must be unable to engage in any substantial gainful activity and have a disability that can be expected to result in death or to last for a continuous period of not less than 12 months; or be statutorily blind within the meaning of the law (central vision acuity of 20/200 or less in the better eye with corrective lens).

The duration of the disability can be calculated from the reported date of onset.

Primary and secondary diagnoses are classified according to a special diagnosis list and the *International Classification of Diseases*.

Statutorily blind? Yes/no.

Mobility: Institutionalized, confined to general hospital, bedridden (home), chairbound, housebound, go outside with help, go outside without help.

## Family Composition

Number of children under age 18 (1, 2, . . . 8, 9 or more).

## Beneficiary Status for Major Federal Programs

Railroad retirement benefits, Social Security Disability Insurance, supplemental medical insurance.

## Other Health Related Data

Not reported.

## Other Demographic Data

Sex, longest full-time occupation, education.

## Geographical Area

State:

Reported.

Region:

Not reported.

SMSA:

Not reported.

## Service Utilization

Not reported.

## AVAILABILITY OF DATA

Restricted use tapes may be made available for approved purposes upon request to the Director of the Office of Disability Studies. Such requests must show adequate justification. Sponsorship by another government agency typically increases the chances of approval. Information by which users could conceivably identify individual beneficiaries is removed from the tapes prior to release. Cost of the tapes is calculated on a request by request basis.

## User Representative

Audrey Coe  
Division of Disability Studies  
Office of Research and Statistics

Social Security Administration  
6401 Security Boulevard  
Baltimore, MD 21235  
(301) 594-0721

## TAPE CHARACTERISTICS

### Density

1600 bpi.

### Number of Tracks

Nine.

### Magnetic Recording Code

EBCDIC.

### Preformatted

No.

### Data Structure

Rectangular.

### Technical Documentation

Continuous Disability History Sample Restricted Use Data File: Description and Documentation. Undated. Baltimore: Social Security Administration, Office of Research and Statistics, Pub. No. 024(11-78).

## SURVEY EVALUATION

### Narrative Assessment

It is not possible to estimate the total number of individuals on the rolls at a given point in time from these sample data. Only those persons applying for and satisfying SSDI eligibility requirements each year are included. Disabled persons

not included on the rolls would be those who do not have a medically determinable impairment, who are not totally work disabled, who would be eligible but failed to apply, and persons aged 65 and over who are classified as aged regardless of whether they have a work disability.

## CURRENT POPULATION SURVEY (CPS) MARCH INCOME SUPPLEMENT

### CONTACT

Kathleen Creighton  
Demographic Surveys Division  
Current Population Surveys Branch  
Bureau of the Census  
U.S. Department of Commerce  
Washington, DC 20233  
(301) 763-2773

### SPONSOR

Bureau of the Census  
Bureau of Labor Statistics  
Department of Health and Human Services

### PERIOD

The CPS is a monthly survey that began in 1940. The March Income Supplement occurs annually (every March) and has included information on disability since 1981.

### SURVEY DESCRIPTION

#### Survey Objectives

The main purpose of the CPS is to collect information on the employment situation and the demographic status of the population. The March Income Supplement builds on the monthly demographic and labor force data collected in the basic survey adding questions on work experience, income, noncash benefits and migration. The work experience section includes information on disability.

#### Population Surveyed

Persons interviewed are drawn from the civilian noninstitutionalized population of the United States age 14 and over

### Prior Users and Use Reports

John W. Ashbaugh  
Human Services Research Institute  
2336 Massachusetts Avenue  
Cambridge, MA 02140  
(617) 876-0426

*Characteristics of Social Security Disability Insurance Beneficiaries.* Baltimore: Social Security Administration, Office of Research and Statistics, November 1983. (Like statistical reports have been published each year since 1957.)

*Social Security Bulletin: Annual Statistical Supplement, 1977-79.* Baltimore: Social Security Administration, Office of Research and Statistics, September 1980. (Social Security Bulletins have been published annually with monthly summaries and supplements since 1955.)

Kahn, Arthur L. and Rasberry, Theodisia P. *Program and Demographic Characteristics of Supplemental Security Income Beneficiaries.* Baltimore: Social Security Administration, December 1978.

living in housing units, and from male members of the armed forces living in civilian housing units on a military base or in households not on military bases.

### Survey Size

In 1984 approximately 122,000 persons were interviewed from roughly 58,000 households. The March Supplement contains an additional sample of 2,500 Spanish households.

### Survey Design

The CPS is a probability sample based on a stratified sampling scheme. The sample is selected from lists of addresses obtained from the most recent decennial census and updated for new construction.

In the first stage of sampling, primary sampling units (PSU's) are selected. These PSU's are stratified according to characteristics intended to maximize the reliability of estimates (e.g., employment statistics by sex, employment statistics by occupation, etc.). Until recently strata were regionally based and could cross state boundaries; however, all strata are now defined within state boundaries and the sample is allocated among the states to produce state and national estimates. Within each stratum, a single PSU is chosen with a probability proportional to its population as of the most recent decennial census. This PSU represents the entire stratum from which it was selected.

In the second stage a sample of addresses is selected from decennial census lists within the representing PSU. For a relatively small portion, an additional stage of selection within the PSU is necessary.

This two stage process is roughly equivalent to the simple plan of dividing each state into ultimate sampling units (USU's), each containing about four neighboring housing units, and selecting clustered samples of these USU's for interview.

Each sample is divided into eight approximately equal rotation groups. A rotation group is interviewed for four consecutive months, temporarily leaves the sample for eight months and then returns for four more consecutive months before retiring permanently from the CPS. The March Income Supplement is administered to all households for the month of March.

This is a new design phased in over a 16-month period from April 1984 to July 1985. It is expected to provide better state-based estimates than the old design. The anticipated effects of these changes in design on estimates derived from the CPS during the phase-in period are described in an undated publication (Creighton and Wilkinson, see "Technical Documentation Section").

### Data Source

Personal and telephone interviews.

### Estimation (Case Weighting) Scheme:

Weighting for all CPS data is the product of several adjustments:

- (1) Basic weight, which represents the probability of selection;
- (2) Adjustment for special sampling situations;
- (3) Noninterview adjustment;
- (4) First-stage ratio adjustment to reduce the variance associated with sampling PSU's;
- (5) Second-stage ratio adjustment to independently derived current estimates of the population in a number of age-sex-race groups.

An additional weight is prepared for the earnings universe using a simple ratio estimation, corresponding to wage and salary workers in the two outgoing rotations (Note: The

survey is administered in rotation groups; see “Survey Design”). Finally, due to differences in the questionnaire, sample and data uses of the March Supplement, tabulations based on March Supplement items received three additional weights:

- (1) March supplement person weight;
- (2) Household weight;
- (3) Family weight.

### **Response Rates**

For March 1984, the overall CPS response rate is 96 percent.

### **Treatment of Missing Values**

All missing and inconsistent entries are imputed.

### **Sampling Error**

Standard error tables and discussion of reliability issues are published routinely by the Census Bureau in a “Source and Reliability Statement” as part of each Census Bureau report.

## **KEY VARIABLES AND VARIABLE BREAKDOWNS**

### **Age**

Coded in single years.

Recode 1: Not in universe, 15 years, 16-17, 18-19, 20-21, 22-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-61, 62-64, 65-69, 70-74, 75 and over.

Recode 2: Under 18 years, 18-64, 65 and over.

### **Race/Ethnicity**

Racc: White, Black, other.

Spanish Ethnicity: Seven categories (e.g., Mexican, Puerto Rican, Cuban, etc.).

### **Family Income**

- (1) Wages and salaries in dollar amount;
- (2) Total family income from all sources, in dollar amount;
- (3) National family income ranking coded in 5 percent increments;
- (4) Family income to poverty level (i.e., below poverty level, 100-124 percent of poverty level, etc.);
- (5) Ratio of family income to poverty level (i.e., under .50, .50 to .74, etc.)

### **Employment Status**

Reported.

### **Rural/Urban Residence**

Not reported for 1985; reported for 1984.

### **Disabling Conditions/Functional Limitations**

(For persons not working and not looking for work during the past 4 weeks): What are the reasons...is not looking for work?—Ten response categories including “ill health, physical disability.”

Does anyone in this household have a health problem or disability which prevents them from working or which limits the kind or amount of work they can do? Who is that?

For 1985, the following data on service-connected disability may be obtained:

Is there anyone in this household who has a service-connected disability or who ever retired or left a job for health reasons? Who is that?

(For persons who have served on active duty in the U.S. Armed Forces): Has the V.A. or Department of Defense determined that you have a service-connected disability; that is, a health condition or impairment caused or made worse by military service?

What is your service-connected disability rating? 0%, 10%, 20%...100%

### Family Composition

Number of persons in family.

Kind of Family: Family, related subfamily, unrelated subfamily, nonfamily householder, unrelated individuals.

Type of Family: Married couple family; other family, male householder; other family, female householder.

Relationship to Householder: Householder with other relatives, nonfamily householder, spouse of householder, child of householder, other relative of householder, unrelated subfamily member, unrelated individual.

Family Relationship: Not in related or unrelated subfamily, reference person (related or unrelated subfamily), spouse (related or unrelated subfamily), child, (related or unrelated subfamily), other relative (unrelated subfamily).

### Beneficiary Status for Major Federal Programs

Energy assistance, food stamps, housing support, school lunches, Social Security, Supplemental Security Income, Veterans Administration or Civil Service survivor and retirement benefits, educational assistance (e.g., Basic Educational Opportunity Grant), Aid to Families with Dependent Children, various insurance sources for disability, Medicaid, CHAMPUS.

### Other Health Related Data

Not reported.

### Other Demographic Data

Marital status, sex, veteran status, education.

### Geographical Area

State:

Reported.

Region:

Northeast, North Central, South, West.

New England, Middle Atlantic, East North Central, West North Central, South Atlantic, East South Central, West South Central, Mountain, Pacific.

SMSA:

Reported (top 44 SMSA's plus metropolitan/nonmetropolitan for most States).

### Service Utilization

Not reported.

### AVAILABILITY OF DATA

#### Price of Tapes

1600 bpi (3 reels): \$420.

6250 bpi (1 reel): \$140.

#### User Representative

Kathleen Creighton  
Demographic Surveys Division  
Current Population Surveys Branch  
Bureau of the Census  
U.S. Department of Commerce



Washington, DC 20233  
(301) 763-2773

Order point:

Data User Services Division  
Bureau of the Census  
U.S. Department of Commerce  
Washington, DC 20233  
(301) 763-4100

## TAPE CHARACTERISTICS

### Density

1600 or 6250 bpi.

### Number of Tracks

Nine.

### Magnetic Recording Codes

EBCDIC or ASCII.

### Date Structure

Hierarchical.

### Preformatted

No.

### Technical Documentation

*Current Population Survey, March 1984 Technical Documentation.*  
Bureau of the Census, 1984.

*Current Population Survey: Design and Methodology. Technical Paper  
#0.* Bureau of the Census, January 1978.

Creighton, Kathleen, P. and Wilkinson, Robert. *Redesign  
of the Sample Current Population Survey.* Bureau of the Census,  
undated.

## SURVEY EVALUATION

### Narrative Assessment

The March Income Supplement provides data pertaining to work disability. It includes extensive information on other characteristics (e.g., income, demographic), but provides little data on severity or duration. In addition, it underestimates disability income, and fails to provide categorical information necessary to produce reliable estimates of program eligibility. Because the case weighting scheme changed with the March 1981 Income Supplement, caution should be exercised when comparing 1981 through 1984 estimates with those from previous years.

### Prior Users and Use Reports

Data from the March Current Population Survey are published in the Current Population Reports P-20 (Population Characteristics) and P-60 (Consumer Income) series, which are available by subscription from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

*Using the Current Population Survey as a Longitudinal Data Base.*  
Report 608. Bureau of Labor Statistics, August 1980.

McNeil, John M. *Labor Force Status and Other Characteristics of Persons with a Work Disability: 1982*, Current Population Reports, Series P-23, No. 127. Bureau of the Census, July 1983.

# FAIR LABOR STANDARDS ACT, SHELTERED WORKSHOP DATA

## CONTACT

Howard Ostmann  
Branch of Special Employment  
Wage and Hour Division  
U.S. Department of Labor  
200 Constitution Avenue  
Washington, DC 20210  
(202) 523-8727

## SPONSOR

Wage and Hour Division  
U.S. Department of Labor

## PERIOD

Annually, since about 1960.

## SURVEY DESCRIPTION

### Survey Objectives

These data are gathered and maintained in order to administer that part of the minimum wage law allowing for a lower minimum wage for handicapped workers. Sheltered employment settings, in order to qualify for the lower minimum wage, must supply the federal government with these data.

### Population Surveyed

All sheltered employment settings seeking to qualify for the lower minimum wage for handicapped workers provide data on employed workers.

## Survey Size

5,120 workshops holding certificates as of the end of FY 1985, employing 245,043 clients during that year; including 20,678 clients in evaluation and training.

## Survey Design

Not applicable.

## Data Source

Sheltered employment sites furnish the data on reporting forms that are submitted annually to the Federal government.

## Estimation (Case Weighting) Scheme

Not applicable.

## Response Rates

Not applicable.

## Treatment of Missing Values

Not applicable.

## Sampling Error

Not applicable.

## KEY VARIABLES AND VARIABLE BREAKDOWNS

### Age

Not reported.

### Race/Ethnicity

Not reported.



## Family Income

Not reported.

## Employment Status

Reported (by definition, all reported workers are employed).

## Rural/Urban Residence

Not reported.

## Disabling Conditions/Functional Limitations

Workshops must report the type of disability for each client; however, no standard taxonomy is used. Disabilities typically are reported as cerebral palsy, mental retardation, etc.

## Family Composition

Not reported.

## Beneficiary Status for Major Federal Programs

Not reported.

## Other Health Related Data

Not reported.

## Service Utilization

Not reported.

## Geographical Area

Not reported (however, may be determined using the zip code of the sheltered employment setting).

## AVAILABILITY OF DATA

Although these data are public information, they are not set up for easy access. Currently they are maintained manually, and are scheduled to be computerized within a year. At that time tapes may become available.

## SURVEY EVALUATION

### Narrative Assessment

These data are of limited use for estimating the prevalence of disability. They reflect only those persons in sheltered employment at sites seeking approval for paying the lower minimum wage to persons with disabilities. Virtually no other information is available about these individuals except their type of disability, which is not, unfortunately, reported in any uniform way.

### Prior Users and Use Reports

Czajka, John L. *Digest of Data on Persons with Disabilities*. Mathematica Policy Research, Inc. Congressional Research Service, Library of Congress, June 1984. Table II B.6.

*Annual Reports to Congress by the Wage and Hour Division*. U.S. Department of Labor.

# INVENTORY OF MENTAL HEALTH ORGANIZATIONS

## CONTACT

Ronald W. Manderscheid, Ph.D.  
Chief  
Survey and Reports Branch  
Division of Biometry and Applied Sciences  
National Institute of Mental Health  
Room 18-C-07  
5600 Fishers Lane  
Rockville, MD 20857  
(301) 443-3343

## SPONSOR

National Institute of Mental Health (NIMH).

## PERIOD

Biennial; most recent data are from 1983.

## SURVEY DESCRIPTION

### Survey Objectives

To obtain profiles of psychiatric hospitals, residential treatment centers, outpatient mental health clinics, mental health day/night facilities, community mental health centers, and other mental health organizations.

### Population Surveyed

Persons admitted to or resident in mental health organizations.

### Survey Size

In 1983, approximately 3,300 mental health organizations including 350 residential treatment centers (RTC's)

for emotionally disturbed children, and 280 state and county mental hospitals, were included in the inventory.

## Survey Design

The mailing list of mental health organizations is periodically checked by the state mental health authorities, checked against directories published by private associations, and checked by phone with listed organizations.

## Data Source

Mail survey with two mail followups and one phone followup. The phone followup includes only a core set of survey items.

## Estimation (Case Weighting) Scheme

Not applicable.

## Response Rates

The response rate is approximately 98 percent.

## Treatment of Missing Values

Imputed from responses from like facilities matched by size, region and area, and program type.

## Sampling Error

Not applicable.

## KEY VARIABLES AND VARIABLE BREAKDOWNS

### Age

Less than 18 years, 18-64, 65 and over.

**Race/Ethnicity**

White (not Hispanic), Black (not Hispanic), Hispanic, American Indian or Alaskan Native, Asian or Pacific Islander.

Reported.

SMSA:

Not reported.

**Family Income**

Not reported.

**Service Utilization**

Not reported.

**Employment Status**

Not reported.

**AVAILABILITY OF DATA**

Data tapes are available.

**Rural/Urban Residence**

Not reported.

**Price of Tapes**

Available free of charge; however, a blank tape must be provided.

**Disabling Conditions/Functional Limitations**

Persons coded as: Mentally ill, alcoholic/drug abuser, mentally retarded, other.

**User Representative**

Ronald W. Manderscheid, Ph.D.  
Chief  
Survey and Reports Branch  
Division of Biometry and Applied Sciences  
National Institute of Mental Health  
Room 18-C-07  
5600 Fishers Lanc  
Rockville, MD 20857  
(301) 443-3343

**Beneficiary Status for Major Federal Programs**

Not reported.

**Other Health Related Data**

Not reported.

**Other Demographic Data**

Sex.

**TAPE CHARACTERISTICS\*****Density**

6250 bpi.

**Geographical Area**

State:

**Number of Tracks**

Nine.

Reported.

Region:

\*Can be delivered to requester specifications.

## Magnetic Recording Codes

EBCDIC.

## Preformatted

SAS.

## Data Structure

Rectangular.

## Technical Documentation

Unpublished documents available on request.

## SURVEY EVALUATION

### Narrative Assessment

It must be assumed that the person's admission to or residence in a mental health organization indicates that his or her mental illness is disabling.

The data are reported in aggregate thus precluding cross tabulations.

### Prior Users and Use Reports

Tables are prepared for state mental health agencies.

Taube, Carl and Barrett, S.A. (eds). *Mental Health, United States 1985*. Rockville, MD: National Institute of Mental Health, 1985.

# LONG TERM CARE SURVEY OF FUNCTIONALLY LIMITED PERSONS (1982, 1984)

## CONTACT

1982:

Paul Gayer

Office of the Assistant Secretary for Planning  
and Evaluation

Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201  
(202) 245-6613

1984:

Candy Macken

Health Care Financing Administration  
2C13 Oak Meadows Building  
6390 Security Boulevard  
Baltimore, MD 21207

## SPONSOR

Office of Assistant Secretary for Planning  
and Evaluation  
Health Care Financing Administration

## PERIOD

This 1982 survey provides cross-sectional data from June to October 1982. The 1984 followup survey provides longitudinal data on the 1982 respondents in addition to cross-sectional data on new respondents from June to October 1984.

## SURVEY DESCRIPTION

### Survey Objectives

To obtain data on the long term care (LTC) of elderly, functionally limited individuals in households and in institutions. These data are intended to meet two challenges relevant to the care of functionally limited persons: (1) how best to meet the needs of an aging population and (2) how to deal effectively with policy issues of concern to multiple agencies.

### Population Surveyed

1982: Civilian noninstitutionalized population over age 65 having a chronic functional limitation, i.e., a limitation which lasted or was expected to last for three months or longer. A functional limitation could be an activity of daily living (e.g., dressing, bathing, etc.) for which the person needs help or an instrumental activity of daily living (e.g., shopping, managing money) which the person was not able to perform as a result of a health problem or disability.

1984: Followup study on all persons eligible for the 1982 survey; elderly functionally limited persons residing in institutions; a subsample of the persons who were screened and were not eligible for the full survey in 1982 (to obtain data on factors contributing to and deterring residence in institutions and on the incidence of functional limitations over a two-year period); a sample of persons who turned age 65 after the 1982 survey.

### Survey Size

36,000 selected names screened; 6,500 persons selected from the screening process for a detailed interview; 2,000 caregivers interviewed.

## Survey Design

The sample is drawn from the 376 Census Bureau A-design strata, collapsed to 173 long term care, primary sampling units (PSU's) with a predetermined probability of inclusion (used to calculate sample selection parameters). Persons are selected from subfiles of the Health Insurance Master File and stratified by age, race, and original reason for Medicare entitlement. In order to obtain reliable estimates of the number of bedfast elderly, the required sample size is determined to be 6,000. These are selected through the following steps: (1) the 55,000 names on the Health Insurance Master File are collapsed into 100 reduction groups based on geographic location, (2) 15,000 names are prescreened to obtain the desired sample size, (3) 36,000 names selected by randomly eliminating whole reduction groups are screened, (4) 6,500 persons requiring long term care are selected for the final sample to receive a detailed interview. From these interviews, 2,000 providers of informal care to the elderly are identified and interviewed as well.

### Data Source

Screening interviews for the most part done by phone. Detailed and caregiver interviews done in person.

### Estimation (Case Weighting) Scheme

Survey sample responses are inflated to U.S. population estimates using weights provided by the 1980 Census.

### Response Rates

Screening interviews: 95.9 percent.  
Detailed interviews: 95.3 percent.  
Caregiver survey: 92 percent.

### Treatment of Missing Values

Missing values are left as blanks on tapes and are coded as missing.

## Sampling Error

Standard error tables are included in the documentation.

## KEY VARIABLES AND VARIABLE BREAKDOWNS

### Age

65-74 years, 75-79, 80-84, 85 and over.

### Race/Ethnicity

16 categories of ethnic origin (e.g., German, Russian, Mexican-American, etc.) plus "other" and "unknown."

### Family Income

Less than \$3,000; 4,000-4,999; 5,000-5,999; 6,000-6,999; 7,000-7,999; 8,000-8,999; 9,000-9,999; 10,000-11,999; 12,000-14,999; 15,000-19,999; 20,000-24,999; 25,000-29,999; 30,000-39,999; 40,000-49,999; 50,000 and over; refused; don't know.

### Employment Status

Reported for those who usually work 30 hours a week or more.

### Rural/Urban Residence

Open country/not a farm, farm, city-town/village (under 50,000), city (50,000-250,000), suburb of large city, large city (over 250,000).

### Disabling Conditions/Functional Limitations

Do you *now* have any of the following chronic health problems: Rheumatism or arthritis, paralysis, other permanent numbness or stiffness (besides paralysis/rheumatism or arthritis), multiple sclerosis, cerebral palsy, epilepsy, Parkinson's disease, glaucoma, diabetes, cancer, frequent constipation, frequent trouble sleeping, frequent severe

headaches, obesity or are you overweight, arterial sclerosis or hardening of the arteries.

Is respondent mentally retarded, senile?

Have you had any of the following in the *last* 12 months: A heart attack, any other heart problem, hypertension or high blood pressure, a stroke, circulation trouble in your arms or legs, pneumonia, bronchitis, flu, emphysema, asthma, a broken hip, other broken bones.

The survey also includes about 75 questions on help required with activities of daily living (ADL) (bathing, dressing, getting to the bathroom or using toilet, getting in or out of bed, getting around inside, eating, continence), and a few more questions on help with instrumental activities of daily living (IADL) (housework, laundry, cooking, etc.)

Data are presented for numbers of ADL limitations and type of assistance needed (no assistance, special equipment, personal help only, completely dependent).

There are approximately 20 questions on range of motion and impairment, including questions about missing limbs, flexibility, speech, hearing, and comprehension.

In addition there are several related questions: Respondents' view of their physical and emotional health, contacts with friends and relatives, how they spend their time.

## Family Composition

Household composition and relationships. Living children who are not members of the household.

## Beneficiary Status for Major Federal Programs

Extensive information is available for each respondent (all household members age 15 and older) including: Veterans Administration, Medicare/Medicaid, Social

Security, unemployment, workman's compensation, Supplemental Security Income, food stamps, Aid to Families with Dependent Children, other welfare payments.

#### **Other Health Related Data**

Reported.

#### **Service Utilization**

##### **Types of Services**

Physical therapy, occupational therapy, speech therapy, mental health services, medical services.

##### **Level of Utilization**

Reported.

#### **Other Demographic Data**

Sex, military service.

#### **Geographic Area**

The Census region is listed on the data tape.

### **AVAILABILITY OF DATA**

Data tapes and documentation are scheduled to be available in March 1986.

#### **Price of Data or Tapes**

Unknown at present time.

#### **User Representative**

Paul Gayer  
Office of the Assistant Secretary for Planning  
and Evaluation  
Department of Health and Human Services

Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201  
(202) 245-6613

Order Point:

National Technical Information Service  
5285 Port Royal Road  
Springfield, VA 22161  
(703) 487-4763

### **TAPE CHARACTERISTICS**

#### **Density**

6250 bpi.

#### **Number of Tracks**

Nine.

#### **Magnetic Recording Code**

EBCDIC.

#### **Preformatted**

Yes.

#### **Data Structure**

Fixed format.

#### **Technical Documentation**

Documentation with the tapes, from the National Technical Information Service.



## SURVEY EVALUATION

### Narrative Assessment

This survey provides national estimates of prevalence of functional limitations in the aged population along with very detailed information on functional limitations of specific activities of daily living and type or degree of assistance needed. This is the first survey that provides scientifically based data on informal caregivers to the disabled elderly. Longitudinal data can be used to assess the factors associated with nursing home admission.

### Prior Users and Use Reports

Liu, Korbin and Manton, Kenneth. *Disability and Long-Term Care*. Paper presented at the Methodologies of Forecasting Life and Active Life Expectancy Conference, sponsored by NIA, ACLI and HIAA, Bethesda, Maryland, June 1985.

Liu, Korbin and Manton, Kenneth. *Future Growth of the Long-Term Care Population*. Paper presented at the Future World of Long Term Care Conference, Sponsored by the Hill Haven Foundation, March 1984.

Liu, Korbin, Marzetta, Barbara and Manton, Kenneth. Home Care Expense for Noninstitutionalized Elderly with ADL and IADL, *Health Care Financing Review* (in press).

## LONGITUDINAL SUPPLEMENTAL SECURITY INCOME DATA FILES

Two different files are available for restricted public use: (1) the 831 files and (2) the Characteristic Extract Record (CER).

### CONTACT

- 1) Audrey Coe  
Division of Disability Studies  
Office of Research and Statistics  
Social Security Administration  
6401 Security Boulevard  
Baltimore, MD 21235  
(301) 594-0721
- 2) Michael Staren  
Office of Supplemental Security Income  
Mail Stop 36-3  
Social Security Administration  
6401 Security Boulevard  
Baltimore, MD 21235  
(301) 594-3802

### SPONSOR

Social Security Administration.

### PERIOD

- 1) Annually since 1975.
- 2) Annually since July 1981.

### SURVEY DESCRIPTION

#### Survey Objectives

To support special studies of the blind and disabled adults and children participating in Supplemental Security Income (SSI) for purposes of program management.



## Population Surveyed

Persons applying for payments under the Supplemental Security Income Program who meet the following eligibility requirements: They must be incapable of engaging in any substantial gainful activity because of a medically determinable physical or mental impairment that has lasted or can be expected to last continuously for at least 12 months or to result in death. Blindness is defined as central vision acuity of 20/200 or less in the better eye with the use of a corrective lens or tunnel vision of 20 degrees or less. For adults, disability is associated with an inability to work. Disability in children must be evaluated in terms of their growth, maturation of physical and functional characteristics, learning, mastering of basic skills, and emotional and social development (Kochhar, 1979).

Recipients must be indigent having no more than \$1,500 to \$2,500 in the bank and monthly incomes near the poverty level.

## Survey Size

- 1) 831 files for 1983: 67,080.
- 2) One percent files for August 1985: approximately 5,550.

## Survey Design

- 1) The annual sample of disabled beneficiary records is drawn randomly and stratified by state at a sampling rate of 10 percent to 100 percent with the rate decreasing as the total number of cases on the records in each state increases. The sample is not truly longitudinal as each year a sample is drawn independent of the previous year samples, and cases drawn in previous years are not updated.
- 2) One percent sample of complete master file.

## Data Source

Disabled beneficiary records.

## Estimation (Case Weighting) Scheme

Cases have two weights: (1) basic weights which are the reciprocals of the probabilities of case selection and (2) ratio adjustment weights to make the estimated totals agree with previously published award totals in each state.

## Response Rates

Not applicable.

## Treatment of Missing Values

Missing values are shown as such.

## Sampling Error

Estimates of standard errors have not been routinely provided with published statistics. Illustrative sampling error statistics are not available.

## KEY VARIABLES AND VARIABLE BREAKDOWNS

### Age

Month and year of birth.

### Race/Ethnicity

White, Black, other.

### Family Income

Current earned income by six source categories.

Current unearned income by source (up to six of 18 possible categories). If more than six sources, the sixth source is used to summarize the remaining sources.

## **Rural/Urban Residence**

Could be imputed using the county or zipcode of residence together with supplementary information classifying the counties or zipcode areas as urban or rural.

## **Disabling Conditions/Functional Limitations**

SSI beneficiaries must be unable to engage in any substantial gainful activity and have a disability that can be expected to result in death or to last for a continuous period of not less than 12 months; or be statutorily blind within the meaning of the law (central vision acuity of 20/200 or less in the better eye with corrective lens).

The duration of the disability can be calculated from the reported date of onset.

Primary and secondary diagnoses are classified according to a special diagnosis list and the International Classification of Diseases.

Statutorily blind? Yes/No.

Mobility: institutionalized, confined to general hospital, bedridden (home), chairbound, housebound, go outside with help, go outside without help.

## **Family Composition**

Head of household, not head of household.

## **Beneficiary Status for Major Federal Programs**

State welfare or Supplemental Security Income, Medicaid and social services eligibility status, food stamps, veterans benefits (by type).

## **Other Health Related Data**

Not reported.

## **Other Demographic Data**

Sex, education, type of living arrangement, and competency.

## **Geographical Area**

State:

Reported.

Region:

Not reported.

SMSA:

Not reported.

## **Service Utilization**

### **Types of Services**

Vocational rehabilitation program involvement, drug/alcohol treatment.

### **Level of Utilization**

Not reported.

## **Employment Status**

Information reported sufficient to determine employment status.

## **AVAILABILITY OF DATA**

Restricted use tapes may be made available for approved purposes upon request to the Associate Commissioner, Supplemental Security Income. Such requests must show adequate justification. Sponsorship by another government agency typically increases the chances of approval.

Information by which users could conceivably identify individual beneficiaries is removed from the tapes prior to release.

#### Price of Data or Tapes

Determined on a case by case basis.

#### User Representative

- 1) Audrey Coc  
Division of Disability Studies  
Office of Research and Statistics  
Social Security Administration  
6401 Security Boulevard  
Baltimore, MD 21235  
(301) 594-0721
- 2) Michael Staren  
Office of Supplemental Security Income  
Mail Stop 36-3  
Social Security Administration  
6401 Security Boulevard  
Baltimore, MD 21235  
(301) 594-3802

#### TAPE CHARACTERISTICS

##### Density

1600 bpi.

##### Number of Tracks

Nine.

##### Magnetic Recording Code

EBCDIC.

#### Preformatted

No.

#### Data Structure

Rectangular.

#### Technical Documentation

*Supplemental Security Income Data Element Dictionary.*  
Baltimore: Social Security Administration, U.S.  
Department of Health and Human Services, July 1985.

#### SURVEY EVALUATION

##### Narrative Assessment

- (1) It is not possible to estimate the total number of individuals on the rolls at a given point in time from these sample data. Only those persons applying for and satisfying SSI eligibility requirements each year are included. Disabled persons not included on the rolls are those who do not have a medically determinable impairment, who are not totally work disabled, who would be eligible but failed to apply, and persons aged 65 and over who are classified as aged regardless of whether they have a work disability.
- (2) Only 25 percent of the CER file contains legitimate disability codes. Disability codes on most cases have been included only since 1982.

##### Prior Users and Use Reports

John W. Ashbaugh  
Human Services Research Institute  
2336 Massachusetts Avenue  
Cambridge, MA 02140  
(617) 876-0426

Kochhar, Satya, Blind and Disabled Persons Awarded Federally Administered SSI Payments, 1975. *Social Security Bulletin*, #2 (6), June 1979.

## MEDICAID STATISTICAL REPORT DATA (HCFA FORM 2082)

### CONTACT

Aggregate data:

Tony Parker  
Chris Howe  
Office of the Actuary  
Medicaid Statistics Branch  
Health Care Financing Administration  
J-1, EQ05  
3625 Security Boulevard  
Baltimore, MD 21207  
(301) 597-1417 (Tony Parker)  
(301) 597-3302 (Chris Howe)

Individual record data:

Rick Beisel  
Office of the Actuary  
Medicaid Statistics Branch  
J-1, EQ05  
6325 Security Boulevard  
Baltimore, MD 21207  
(301) 594-8099

### SPONSOR

Health Care Financing Administration.

### PERIOD

Annually since the early 1970's.

Note: An individual record data reporting option submitted quarterly and containing some month-by-month information is being instituted by HCFA. See below for further explanation.

## **SURVEY DESCRIPTION**

### **Survey Objectives**

All state agencies administering or supervising an approved plan for a Federally aided Title XIX (Medicaid) program must submit to the Federal government the basic information requested on the HCFA 2082 form. This information is used for program evaluation, budgeting, planning and for answering inquiries at the Federal level.

### **Population Surveyed**

Medicaid eligibles and recipients of Medicaid-funded services.

Data on Medicaid recipients only are available for years prior to 1985. Beginning in 1984, partial data on Medicaid eligibles are collected as well.

### **Survey Size**

Currently 49 states (Arizona does not participate), the District of Columbia, Virgin Islands and Puerto Rico participate in the federally aided Medicaid program. In FY 1984 there were 21,603,665 Medicaid recipients. The HCFA 2082 aggregate data revealed 2,833,964 disabled recipients in FY 1984.

### **Survey Design**

All state agencies administering or supervising the administration of an approved plan for a federally aided Title XIX program are required to report.

States electing to submit individual data instead of the hard-copy aggregate data must submit five files necessary to reproduce the HCFA 2082 form:

- (1) Paid claims for "Inpatient Hospital Care"
- (2) Paid claims for all "Other (Long Term) Institutional Care"

- (3) "Other Paid Claims"

- (4) "Eligibles" data file, containing basic information on all eligibles

- (5) "Provider" data file, containing basic information on all providers.

Reporting on the HCFA 2082 form is mandatory and includes a 100 percent count of all requested information.

### **Data Source**

HCFA form 2082 (or sample data tapes) are prepared and submitted by state agencies.

Now States have the option of submitting individual record data in lieu of the aggregate data reported on the hardcopy HCFA 2082 form. States electing this option submit data on every Medicaid eligible person and on every claim. Under this option, states are required to submit all of the data necessary to reproduce the HCFA 2082 form; many states supply additional information as well.

### **Estimation (Case Weighting) Scheme**

Not applicable.

### **Response Rates**

The response rate by states is 100 percent; it is required in order to receive Federal aid.

### **Treatment of Missing Values**

Missing values for the HCFA 2082 hardcopy are followed up by HCFA through its regional offices. Any information still missing is estimated based upon historical data.

States electing the individual record reporting option may code variables as either "missing/unknown" or "not applicable." HCFA provides guidelines regarding the max-

imum number of missing data allowable for each variable, and follows up with states that exceed these limits.

### **Sampling Error**

There is no sampling error associated with the number of disabled recipients reported on the HCFA 2082 hardcopy nor with estimates of the number of disabled eligibles based upon the individual record option; 100 percent are reported.

## **KEY VARIABLES AND VARIABLE BREAKDOWNS\***

### **Age**

Aggregate Data (1)\*:

Not reported.

Aggregate Data (2)\*:

Separately for eligibles and recipients: Under 1 year, 1-5, 6-14, 15-20, 21-44, 45-64, 65-74, 75-84, 85 and over.

Individual Record Data\*:

Date of birth.

### **Race/Ethnicity**

Aggregate Data (1):

Not reported.

### **Aggregate Data (2):**

Separately for eligibles and recipients: White, not of Hispanic origin; Black, not of Hispanic origin; American Indian or Alaskan Native; Asian or Pacific Islander; Hispanic.

Individual Record Data:

Same as for Aggregate Data (2).

### **Family Income**

Not reported.

### **Employment Status**

Not reported.

### **Rural/Urban Residence**

Not reported.

### **Disabling Conditions/Functional Limitations**

Aggregate Data (1):

Recipients are coded into one of six categorical eligibility groups: Aged, blind, disabled, children in families with dependent children, adults in families with dependent children, other Title XIX recipients.

Blind and disabled eligibility criteria for Medicaid are generally those used by the Social Security Administration to determine eligibility for Supplemental Security Income cash assistance benefits, although a few states use more restrictive definitions.

The basic disability criteria are that a person must be unable to engage in any substantial gainful activity, and have a disability that can be expected to result in death or to last for a continuous period of not less than 12 months; or be

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\*Reported as available from the following sources: (1) Selected aggregate data tapes from HCFA 2082 pages 1-8, which is up-to-date information on numbers of Medicaid recipients and medical vendor payments; (2) aggregate data tapes from HCFA 2082 pages 9-47, based on the 1985 version of the 2082 form, which includes additional data on Medicaid eligibles and recipients; recipient data are currently available only through 1983, and data on eligibles are available beginning in 1985; (3) individual record data available as a reporting option (see "Data Source" above), but not yet available to users.



statutorily blind within the meaning of the law (central vision acuity of 20/200 or less in the better eye with corrective lenses).

#### Aggregate Data (2):

Same as above, with the addition of data gathered on eligibles.

#### Individual Record Data:

Separately for eligibles and recipients: Aged, blind, disabled, children in families with dependent children, adults in families with dependent children, other Title XIX, State assistance, refugee/other Federal, other.

International Classification of Diseases (9th Revision) (ICD-9) codes are obtained for recipients.

### Family Composition

Not reported.

### Beneficiary Status for Major Federal Programs

#### Aggregate Data (1):

Recipients coded in the six categorical eligibility groups are further grouped into one of three subgroups: Receiving maintenance assistance, not receiving maintenance assistance, medically needy.

Maintenance assistance includes: Aid to Families with Dependent Children, Supplemental Security Income, mandatory State supplements, optional state supplements, and adoption assistance or foster care maintenance payments for children.

Medically needy refers to persons with incomes exceeding the limit to qualify for Medicaid but with inadequate resources to meet medical expenses.

#### Aggregate Data (2):

Same as above, available for eligibles as well.

Receipt of Aid to Families with Dependent Children can be determined for eligibles and recipients.

Receipt of Medicare Part B premiums can be determined for eligibles.

Medicare deductibles and coinsurance payments can be determined separately for aged and disabled recipients.

Receipt of State assistance, refugee program, or other health benefits is available for recipients.

#### Individual Record Data:

Same as for Aggregate Data (2). In addition, receipt of refugee/other Federal assistance can be determined for eligibles and recipients.

### Other Health Related Data

Not reported.

### Other Demographic Data

#### Aggregate Data (1):

Not reported.

#### Aggregate Data (2):

Sex.

#### Individual Record Data:

Sex, date of death, county of residence.

## Geographical Area

State:

Reported for all three data sources.

Region:

Not reported.

SMSA:

Not reported.

## Service Utilization

### Types of Services

Nineteen different medical and related services including: Inpatient mental health services (three types), intermediate care facility services for mentally retarded persons, skilled nursing facility services, home health services, etc.

### Level of Utilization

Aggregate Data (1):

Expenditures only are reported.

Aggregate Data (2):

Level is reported for some services in addition to expenditure data.

Individual Record Data:

Level is reported for some services in addition to expenditure data.

## AVAILABILITY OF DATA

Aggregate data tapes are available separately for HCFA 2082 pp. 1-8 and pp. 9-47. Individual record data are not yet available and will not be available for several years.

### Price of Data or Tapes

Currently there is no charge for tapes; however, due to increases in tape requests a charge may be instituted.

### User Representative

Inquiries and orders for HCFA 2082 may be directed to:

Kim Wivell  
Office of the Actuary  
Medicaid Statistics Branch  
Health Care Financing Administration  
J-1, EQ05  
6325 Security Boulevard  
Baltimore, MD 21207  
(301) 594-8051

Inquiries regarding individual record data tapes may be directed to:

Dr. Richard Bale  
Office of the Actuary  
Medicaid Statistics Branch  
Health Care Financing Administration  
J-1, EQ05  
6325 Security Boulevard  
Baltimore, MD 21207  
(301) 597-6107

## TAPE CHARACTERISTICS

### Density

6250 bpi.

## Magnetic Recording Codes

Not reported.

## Preformatted

SAS.

## Data Structure

Aggregate.

## Technical Documentation

A computer-run technical description of tape contents is provided with each tape request.

## SURVEY EVALUATION

### Narrative Assessment

The only up-to-date disability information available from Medicaid is limited data on the numbers of blind or disabled recipients of Medicaid funded services. Slightly more detailed information (e.g., age, race) on recipients is available. In addition, similar information for eligibles is available for some States for 1984 and 1985. The individual record data reporting option represents the best hope for more comprehensive data on persons eligible for Medicaid due to disability; however, it is not likely to be operational and available for several years.

### Prior Users and Use Reports

LaJolla Management Corporation. Analysis of State Medicaid Program Characteristics. Prepared for Department of Health and Human Services (1982, 1983) and prepared by DHHS in 1984.

*Medicaid/Medicare Data Book* (Annual). Baltimore: Health Care Financing Administration, 1984.

## MEDPAR PUBLIC USE FILE

## CONTACT

Janet O'Leary  
Irving Goldstein  
Office of Statistics and Data Management  
Bureau of Data Management and Strategy  
Health Care Financing Administration  
1-F-2 Oak Meadows Building  
6325 Security Boulevard  
Baltimore, MD 21207  
(301) 597-2070

## SPONSOR

Health Care Financing Administration.

## PERIOD

Data compiled annually since 1966. Public use tapes available since 1981.

## SURVEY DESCRIPTION

### Survey Objectives

This national sample file containing billing and medical data on a sample of Medicare beneficiaries (as reported on Medicare short-stay hospital inpatient bills) is maintained as part of the mandated effort to measure the effects of Medicare on the population.

### Population Surveyed

Medicare beneficiaries using short-stay hospital inpatient services. Persons are eligible for Medicare if they meet one of the following criteria: (1) over age 65 and entitled to Social Security benefits, (2) disabled and entitled to Social Security disability benefits for at least two years, or (3) kidney patient (end stage renal disease).

### Survey Size

Twenty percent of the population (as stated above) comprises the sample each year. The 1984 file consists of just over two million discharge records.

### Survey Design

The file contains a 20 percent sample of Medicare beneficiaries using short stay hospital inpatient services. The sample is determined by the terminal digits in the beneficiary's health insurance claim number.

### Data Source

Short-Stay Hospital Inpatient Bills (HCFA-1453 form, HCFA-1450 from 1985 on).

### Estimation (Case Weighting) Scheme

Not applicable.

### Response Rates

Not applicable.

### Treatment of Missing Values

Data are coded and cleaned at the intermediary level (i.e., insurance companies) where missing data are sought. Data still missing after the follow up are coded as "0" and retained in the file.

### Sampling Error

Standard errors may be computed.

## KEY VARIABLES AND VARIABLE BREAKDOWNS

### Age

Age in years as of date of admission.

### Race/Ethnicity

Not reported.

### Family Income

Not reported.

### Employment Status

Not reported.

### Rural/Urban Residence

Not reported.

### Disabling Conditions/Functional Limitations

Principal diagnosis coded according to the International Classification of Diseases, 9th Revision, (ICD-9-CM) and assigned to Diagnostic Related Group (DRG).

### Family Composition

Not reported.

### Beneficiary Status for Major Federal Programs

The entire sample consists of Medicare beneficiaries. No other programs are reported.

### Other Health Related Data

Reported.

### Other Demographic Data

Sex.

## Geographical Area\*

State:

Not reported.

Region:

Not reported.

SMSA:

Not reported.

## Service Utilization

### Types of Services

Medical services delivered in hospital: Intensive care unit, coronary care unit, pharmaceutical, lab, radiology, supplies, anesthesia, inhalation, and surgical procedures.

### Level of Utilization

Reported either as days of care or as charge data.

## AVAILABILITY OF DATA

Available on magnetic tape for the years 1980-1984.

### Price of Data or Tapes

\$750.00 per year

### User Representative

Janet O'Leary  
Office of Statistics and Data Management

Bureau of Data Management and Strategy  
Health Care Financing Administration  
1-F-2 Oak Meadows Building  
6325 Security Boulevard  
Baltimore, MD 21207  
(301) 597-2070

## TAPE CHARACTERISTICS

### Density

6250 bpi.

### Number of Tracks

Nine.

### Magnetic Recording Codes

EBCDIC.

### Preformatted

No.

### Data Structure

Sequential.

### Technical Documentation

Public use data file documentation available with tape orders.

## SURVEY EVALUATION

### Narrative Assessment

These data are of limited use for estimating prevalence of disabling conditions, even among Medicare eligible persons for two reasons. First, the universe sampled is limited to

\*Not available on public use tapes, but is available on restricted use tapes that can be purchased by special request.

beneficiaries with short-stay hospital inpatient discharges, *not* all Medicare-eligible persons. Second, ICD-9-CM and DRG codes provided for each claim are not particularly useful for determining disability status. The existence of a disability may be inferred for some conditions or diseases (e.g., cerebral palsy, mental retardation), but not for most. At best then, these data may provide estimates of the prevalence of selected disabling conditions among those Medicare beneficiaries utilizing short-stay hospital services.

#### **Prior Users and Use Reports**

Not available.

## **NATIONAL AMBULATORY MEDICAL CARE SURVEY**

### **CONTACT**

Hugo Koch  
Ambulatory Care Statistics Branch  
National Center for Health Statistics  
3700 East-West Highway  
Hyattsville, MD 20782  
(301) 436-7132

### **SPONSOR**

National Center for Health Statistics.

### **PERIOD**

Annual 1973 to 1981 (no survey in 1982, 1983, or 1984). The survey for 1985 is in process and there are plans to conduct the survey every third year.

### **SURVEY DESCRIPTION**

#### **Survey Objectives**

To collect information about ambulatory patients, their problems, and the resources used for their care.

#### **Population Surveyed**

Nonfederally employed physicians (except anesthesiologists, radiologists, and pathologists) in the contiguous United States are sampled and asked to report on all office visits by ambulatory patients.

#### **Survey Size**

The 1981 sample, drawn from a population of 247,216 physicians, includes 2,846 physicians of which 2,725 are medical doctors and 121 doctors of osteopathy. Of these physicians, 518 are excluded for failing to meet these criteria: (1) being



office based, (2) being engaged principally in patient care activities, (3) being nonfederally employed, and (4) not being in other speciality practices. An additional 526 chose not to participate in the survey. From the 1,807 participating physicians, 43,000 patient records of single office visits are provided, producing a weighted estimate of about 585 million visits in 1981. N.B., the unit of analysis is office visits *not* patients, so the same individual could be selected on repeat office visit(s).

## Survey Design

The sampling frame for the survey is comprised of all physicians contained in the master files maintained by the American Medical Association and American Osteopathic Association. The survey design is a multistage probability sample in which probability samples of primary sampling units (PSU's), physicians practicing within PSU's, and patient visits within physicians' practices are selected. A PSU is a county, group of adjacent counties or a standard metropolitan statistical area (SMSA).

Sampled physicians complete patient records for a systematic random sample of their office visits taking place during a randomly assigned weekly reporting period.

## Data Source

Face-to-face interviews (direct) and on-site self-administered questionnaire (indirect).

## Estimation (Case Weighting) Scheme

A multistage estimating procedure with three components is used: (1) inflation by the reciprocal of the probability of selection, (2) adjustment for non-response, and (3) ratio adjustment to reflect the post stratification made for each of the nine physician specialty groups.

## Response Rates

About 77.5 percent of eligible physicians participated in the 1981 survey. Item nonresponse is less than 2 percent.

## Treatment of Missing Values

Missing data are imputed by randomly assigning a value from a patient record with similar characteristics. Imputations are based on physician specialty, major reason for visit, and broad diagnostic categories.

## Sampling Error

For an estimated 500,000 office visits, the approximate relative standard error is 27.3 percent.

## KEY VARIABLES AND VARIABLE BREAKDOWNS

### Age

Less than 15 years, 15-24, 25-44, 45-64, 65 and over.

### Race/Ethnicity

Race: White, Black, Asian/Pacific Islander, American Indian/Alaskan Native.

Ethnicity: Hispanic origin, Mexican, Puerto Rican, Cuban, Central or South American, other Spanish culture origin regardless of race.

### Family Income

Not reported.

### Employment Status

Not reported.

### Rural/Urban Residence

Metropolitan or nonmetropolitan as defined by the Bureau of the Census and U.S. Office of Management and Budget, and based on actual location of visit.

## Disabling Conditions/Functional Limitations

International Classification of Diseases, 9th Revision (ICD-9). Major reason for visit as judged by physician coded as: Chronic problem (routine), chronic problem (flare-up), post surgery/post injury, nonillness care.

## Family Composition

Not reported.

## Beneficiary Status for Major Federal Programs

The 1985 survey will include a question on expected source(s) of payment. There are eight response alternatives for this question including Medicare and Medicaid.

## Other Health Related Data

Reported.

## Other Demographic Data

Sex.

## Geographical Area

State:

Not reported.

Region:

Geographic location of physician offices: Northeast, North Central, South, West.

SMSA:

Reported.

## Service Utilization

### Types of Services

Diagnostic Services: None, limited history exam, general history exam, Pap test, clinical lab test, X-ray, vision test, endoscopy, mental status exam, other (specify), medication therapy for this visit.

Non-medication therapy ordered or provided at this visit: None, physiotherapy, office surgery, family planning, psychotherapy/therapeutic listening, diet counseling, family social counseling, medical counseling, other (specify).

### Level of Utilization

Not reported.

## AVAILABILITY OF DATA

Data tapes and documentation are available for seven survey years: 1975, 1976, 1977, 1978, 1979, 1980 and 1981.

### Price of Data or Tapes

Tapes for 1981 (and other years): \$145 including documentation. Order No. PB 84 188 960.

Documentation for 1981 ordered separately is \$9.95 plus \$3 handling charge. (Documentation for other years is approximately the same price.) Order No. PB 84 191 196.

### User Representative

Malcolm Graham  
Computer Systems Analyst  
Technical Services Branch  
National Center for Health Statistics  
3700 East-West Highway  
Hyattsville, MD 20782  
(301) 436-7116

Order Point:

National Technical Information Service  
5285 Port Royal Road  
Springfield, VA 22161

Computer products (to order tapes): (703) 487-4763

Sales desk (to order documentation): (703) 487-4650

## TAPE CHARACTERISTICS\*

### Density

1600 or 6250 bpi.

### Number of Tracks

Nine.

### Magnetic Recording Code

EBCDIC.

### Preformatted

SPSS, SAS.

### Data Structure

Rectangular.

### Technical Documentation

*Public Use Data Tape Documentation: 1981 National Ambulatory Medical Care Survey.* National Center for Health Statistics, July 1983.

## SURVEY EVALUATION

### Narrative Assessment

The survey includes only persons seen in office-based practice. Demographic information on patients is limited. This survey provides a rich source of trend information on ambulatory medical care utilization patterns and rates, physician and practice characteristics, and demographic characteristics. The strengths of these data are that they include specific and accurate information on symptoms, diagnoses, and treatment. However, the presence of a disability and the severity of that disability can only be inferred.

### Prior Users and Use Reports

Cypress, B.K. Patterns of Ambulatory Care in General and Family Practice: National Ambulatory Medical Care Survey, January 1980-December 1983. *Vital and Health Statistics, 13 (73)*, September 1983.

Cypress, B.K. Patterns of Ambulatory Care in Obstetrics and Gynecology: The National Ambulatory Medical Care Survey, January 1980-December 1981. *Vital and Health Statistics, 13 (76)*, February 1984.

Cypress, B.K. Patterns of Ambulatory Care in Pediatrics: The National Ambulatory Medical Care Survey, United States, January 1980-December 1981. *Vital and Health Statistics, 13 (75)*, September 1983.

Gardocki, Gloria, McLemore, Thomas and Delozier, James, E. The National Ambulatory Medical Care Complement Survey: United States, 1980. *Vital Health Statistics, 13 (77)*, May 1984.

Koch, H. Utilization of Psychotropic Drugs in Office-Based Ambulatory Care: National Ambulatory Medical Care Survey, 1980 and 1981. *Advance Data from Vital and Health Statistics, 90*, June 1983.

\*For 1981 Survey.

Lawrence, L., and McLemore, T. 1981 Summary: National Ambulatory Care Survey. *Advance Data from Vital and Health Statistics*, 88, March 1983.

## NATIONAL HEAD AND SPINAL CORD INJURY SURVEY

### CONTACT

Dallas W. Anderson, Ph.D.  
Office of Biometry and Field Studies  
National Institute of Neurological and Communicative  
Disorders and Stroke (NINCDS)  
National Institutes of Health  
Bethesda, MD 20892  
(301) 496-3256

### SPONSOR

National Institute of Neurological and Communicative  
Disorders and Stroke (NINCDS).

### PERIOD

1970-1974.

### SURVEY DESCRIPTION

#### Survey Objectives

This is one of several surveys to meet NINCDS's need for accurate health statistics. The chief goal of these surveys is to obtain precise national estimates of the incidence, prevalence, and economic costs of selected disorders. These estimates are needed to set priorities, to help allocate health resources, and to assist in regulatory and planning efforts.

#### Population Surveyed

The survey population consists of persons who received inpatient care from hospitals located in the contiguous United States during the time interval 1970 through 1974.

## Survey Size

The sample consists of 9,745 medical records from 247 hospitals cooperating in the survey (selected from an original sample of 305 hospitals). Health cost data are included for 609 patients.

## Survey Design

Probability sampling in three stages is used. In the first stage, the contiguous United States is divided into smaller geographic areas or primary sampling units (PSU's). A PSU is a county or a group of counties. The 1,675 PSU's are stratified by major geographic region and population density. Fifty-eight PSU's are selected randomly from the resulting strata.

In the second stage, hospitals in each of the 58 PSU's are identified using the Master Facility Inventory (MFI) supplemented by another hospital listing of subsequent hospital closings and openings. The MFI is a census of all inpatient health facilities conducted every two or three years by the National Center for Health Statistics.

Each hospital is classified as federal or nonfederal, and each nonfederal hospital is classified by the number of beds, and as a short-term or long-term facility. This classification helps to differentiate those hospitals likely to receive head and spinal cord injured patients.

In the third state, patient records at the participating hospitals are selected randomly. An unduplicated list of discharges showing diagnostic codes that possibly or probably indicate head or spinal cord injury is identified, yielding 204,122 medical records. Of these records, 9,745 are selected randomly and then screened for head or spinal cord injury. The resulting medically eligible sample consists of 3,516 records. Medically eligible records include documentation on the following characteristics: (1) a physical injury to the brain and spinal cord caused by an external (mechanical) force, (2) inpatient care as a result of injuries suffered in traumatic incidents, and (3) injury that did not result in death prior to reaching the hospital.

## Data Source

Medical record reviews (indirect) and a personal interview with patients or relatives of patients (direct).

## Estimation (Case Weighting) Scheme

Estimation of occurrence of head and spinal cord injury is produced from a computer program using formulas (weights) reflecting the complexity of the sample design. The 1970 decennial census data and reports of the current population survey provide the basis for estimating population size.

## Response Rates

<i>Eligible Sample</i>	<i>Type of Data</i>	<i>Response Rate</i>
N = 305 Hospitals	Listing and abstracting of records	93 percent
N = 3,516 Patients	Basic followup interview	50 percent*
N = 913 Patients	Health cost interview	67 percent

## Treatment of Missing Values

Average values are substituted for the missing measurements of each nonresponding head and spinal cord injury case.

## Sampling Error

Relative standard errors (RSE's) are shown for many of the published estimates. RSE's are not available for the estimates of rates because these are ratios of estimates and information needed to compute them was not readily obtainable. Two illustrative RSE's are:

- (1) For an estimated 280,000 males with head injuries, 5.1 percent.

\*Other 50 percent lost due to: (1) inability to locate patient, (2) followup refused by patient, hospital or respondent, or (3) incomplete interview.

- (2) For an estimated 142,000 females with head injuries, 5.7 percent.

## KEY VARIABLES AND VARIABLE BREAKDOWNS\*

### Age

Less than 15 years, 15-24, 25-44, 45-64, 65 and over.

### Race/Ethnicity

White, nonwhite.

### Family Income

Not reported.

### Employment Status

Not reported.

### Rural/Urban Residence

Not reported.

### Disabling Conditions/Functional Limitations

Number of days restricted in major activity prior to and post injury, for any reason; number of days restricted in major activity prior to and post injury, due to illness; number of days restricted in major activity prior to and post injury, as a result of head and spinal cord injury; number of days bedridden for most or all of the day prior to and post injury, due to illness; number of days bedridden for most or all of the days prior to and post injury, due to head and spinal cord injury; number of days of difficulty prior to and post injury in eating or attending to personal hygiene without assistance; number of days of difficulty prior to and post

injury in walking or getting around; number of days of difficulty prior to and post injury in communication.

## Family Composition

Not reported.

## Beneficiary Status for Major Federal Programs

Not reported.

## Other Health Related Data

Reported.

## Other Demographic Data

Sex, marital status, education, occupation, cause of injury.

## Geographical Area

State:

Not reported.

Region:

Northeast, South, North Central, West.

SMSA:

Not reported.

## Service Utilization

### Types of Services

Inpatient services, outpatient services, health care in the home, hospitalization (small, short term, nonfederal; large, short term, nonfederal; long term federal and/or all others).

\*Reported as available in published documents (see "Prior Users and Use Reports" below).



## Level of Utilization

Reported for hospitalization. Some cost data also reported.

## AVAILABILITY OF DATA

Data tapes are not available. Two reports on the survey can be ordered:

Anderson, Dallas W. and McLaurin, Robert L. (eds). The National Head and Spinal Cord Injury Survey. *Supplement to the Journal of Neurosurgery*, 53, November 1980.

Kalsbeck, W.D., Powers, C.F., Harwood, H.J., et al. *Survey of the Incidence, Prevalence, and Costs of Head and Spinal Cord Injury*. Final Report, Contract No. NO1-NS4-2334. Research Triangle Park, North Carolina: Research Triangle Institute, 1977.

## Price of Data or Tapes

The first report can be ordered at no charge. The second report costs \$28.95 plus a \$3.00 handling charge.

## User Representative

Order Point:

For Anderson and McLaurin (1980):

Dallas W. Anderson, Ph.D.  
Office of Biometry and Field Studies  
National Institute of Neurological and Communicative Disorders and Stroke (NINCDS)  
U.S. Department of Health and Human Services  
Bethesda, MD 20892  
(301) 496-3256

For Kalsbeck et al. (1977):

National Technical Information Service  
5285 Port Royal Road  
Springfield, VA 22161  
(703) 487-4600

## SURVEY EVALUATION

### Narrative Assessment

The Head and Spinal Cord Injury Survey findings on the occurrence of new cases and the frequency of existing cases of acute injury to the head or spinal cord show many similarities to earlier studies despite wide differences in objectives, definitions, and methods of research. However, there are several limitations to the survey. Prevalence estimates are undercounted for several reasons: (1) individuals who were dead on arrival at the hospital are not included in incidence rates, (2) only persons who received inpatient care after the injury are included, and (3) individuals whose injury occurred prior to 1970 are not included.

### Prior Users and Use Reports

Two reports are listed under "Availability of Data" above.

# NATIONAL HEALTH INTERVIEW SURVEY (NHIS)

## CONTACT

Gerry Hendershot, Ph.D.  
Illness and Disability Branch  
Department of Health and Human Services  
National Center for Health Statistics  
3700 East-West Highway  
Hyattsville, MD 20782  
(301) 436-7089

## SPONSOR

National Center for Health Statistics.

## PERIOD

Data collected weekly, and compiled quarterly and annually beginning in 1957.

Latest period tapes available: 1983.

## SURVEY DESCRIPTION

In 1982, the Division of Health Interview Statistics (DHIS) implemented a number of major changes in the NHIS questionnaire, definitions of some of the variables, and data processing specifications. Where there are differences in variable definitions between NHIS's in 1981 and prior years and NHIS's in 1982 and subsequent years, both sets of definitions are shown. A description of and rationale for these changes, and related explanations for differences in 1981 NHIS and 1982 NHIS findings can be found in *Current Estimates from the Health Interview Survey: United States, 1982* (see Prior Users and Use Reports, below).

Supplements to the NHIS include use of special aids in 1977 and home care in 1979.

## Survey Objective

To obtain information about the amount and distribution of illness, its effect in terms of disability and chronic impairments and the kind of health services people receive.

## Population Surveyed

U.S. civilian noninstitutionalized population.

## Survey Size

Approximately 42,000 households each year.  
Approximately 110,000 persons each year.

## Survey Design

NHIS uses a stratified, multistage design that provides for the selection of samples at each stage with a known probability. In hierarchical order, the stages of selection are primary sampling units (PSU's—a PSU is a county or a small group of contiguous counties); census enumeration districts (ED's); segments (a segment is a cluster of households); households; eligible persons and finally, sample persons.

## Data Source

Personal interviews with adult household residents.

## Estimation (Case Weighting) Scheme

Since the design of NHIS is a complex multistage probability sample, it is necessary to use complex procedures to derive estimates. Four basic operations are involved.

1) Inflation by the reciprocal of the probability of selection. The probability of selection is the product of the probabilities of selection from each step of selection in the design (PSU, segment, and household).

2) Nonresponse adjustment—The estimates are inflated by a multiplication factor that has at its numerator the number

of sample households in a given segment and as its denominator the number of households interviewed in that segment.

3) First-stage ratio adjustment—Sampling theory indicates that the use of auxiliary information that is highly correlated with the variables being estimated improves the reliability of the estimates. To reduce the variability between PSU's within a region, the estimates are ratio adjusted to the 1970 populations with 12 color-residence classes.

4) Poststratification by age-sex-color—The estimates are ratio adjusted within each of 60 age-sex-color cells to an independent estimate of the population of each cell for the survey period.

## Response Rates

In 1981, there was a 3 percent nonresponse rate of which 1.8 percent represented refusal to participate.

## Treatment of Missing Values

Data are adjusted for nonresponse by a procedure that imputes to persons not interviewed in a household the characteristics of persons interviewed in households in the same segment.

## Sampling Error

Examples of relative standard errors are:

<i>Estimate (1981)</i>	<i>Relative Standard Error (1981)</i>
8,568,00 persons with visual impairments	4.8%
1,968,000 persons with speech impairments	10%

## KEY VARIABLES AND VARIABLE BREAKDOWNS

### Age

#### <1981

Age in years up to 98, and 99 + years of age.

Recode #1: 0-4 years, 5-14, 15-24, 25-34, 35-44, 45-54, 55-64, 65-74, 75 and over.

Recode #2: Under 6 years, 6-16, 17-24, 25-34, 35-44, 45-54, 55-64, 65-74, 75 and over.

Recode #3: Under 5 years, 15-44, 45-64, 65 and over.

#### >1982

Recode #1: 0-4 years, 5-17, 18-24, 25-44, 45-64, 65-69, 70-74, 75 and over.

Recode #2: Same as <1981.

Recode #3: Under 3 years, over 3 years.

### Race/Ethnicity

Main Racial Background: White; Black; Asian or Pacific Islander; Aleutian, Eskimo or American Indian; another group not listed; multiple entry; unknown.

Three different recodes of race are also available.

Main Spanish Origin: Puerto Rican, Cuban, Mexican, Mexicano, Mexican American, Chicano, other Latin American, other Spanish, Spanish, Spanish (don't know type), not Spanish origin, unknown.

### Family Income

#### <1981

Less than \$1,000; 1,000-1,999; 2,000-2,999; 3,000-3,999; 4,000-4,999; 5,000-5,999; 6,000-6,999; 7,000-9,999; 10,000-14,999; 15,000-24,999; 25,000 and over.

Recode: Less than \$3,000; 3,000-4,999; 5,000-6,999; 7,000-9,999; 10,000-14,999; 15,000-24,999; 25,000 and over.

>1981

Less than \$1,000; 1,000-1,999; 2,000-2,999; 3,000-3,999; 4,000-4,999; 5,000-5,999; 6,000-6,999; 7,000-7,999; 8,000-8,999; 9,000-9,999; 10,000-10,999; 11,000-11,999; 12,000-12,999; 13,000-13,999; 14,000-14,999; 15,000-15,999; 16,000-16,999; 17,000-17,999; 18,000-18,999; 19,000-19,999; 20,000-24,999; 25,000-29,999; 30,000-34,999; 35,000-39,999; 40,000-44,999; 50,000 and over.

Recode: Less than \$5,000; 5,000-6,999; 7,000-9,999; 10,000-14,999; 15,000-19,999; 20,000-24,999; 25,000-34,999; 35,000-49,000; 50,000 and over.

#### Rural/Urban Residence

In SMSA, in central city; in SMSA, not in central city; non-SMSA, non-farm; non-SMSA, farm.

#### Disabling Conditions/Functional Limitations

While the nominal classifications remain the same the questions (criteria) used in making the classifications change substantially from 1981 to 1982 and subsequent years. The principal changes beginning in 1982 are listed below.

1. The limitation of activity variable was changed in order to classify all individuals based on the ability to perform activities that are usual for their age group. The criteria for determining activity limitation changed most significantly for the elderly. Previously, persons 65 years of age and over who did not report their major activity as keeping house were classified according to their ability to work. The revised version bases major activity limita-

tion for all persons 71 years of age and over on (a) the ability to manage personal care needs, such as eating, bathing, dressing, and getting around one's own home, and (b) the ability to handle other routine needs, including everyday household chores, doing necessary business, shopping, and getting around for other purposes. This revised concept, which replaces "work" with activity more commonly associated with older persons, was introduced to provide more realistic classification criteria for this age group.

2. An additional limitation of activity classification based on the ability to work was included for all persons of working age (18-70 years of age), reflecting the considerable change that the usual activity roles of men and women have undergone since the survey's onset. This added item enables the data user to classify all persons of working age by a single measure (the ability to work). It also resolves a concern with the earlier version: Women who did not work because of a health problem but who could "keep house" were not classified as limited in their major activity, whereas men with this same set of circumstances were, by definition, limited in their major activity.
3. The specific age ranges for the limitation groups were changed. (For instance, the school-age population, for which major activity limitation is defined in terms of school activities, was changed from 6-16 to 5-17 years of age.) Now age categories more closely correspond to commonly accepted age groups associated with the preschool, school-age, working, and retired populations.
4. The phrases used in the limitation of activity questions—"because of . . . health" and "because of a disability or health"—were changed to "because of an impairment or health problem." This more clearly informs respondents that they should report activity limitations due to all kinds of handicaps as well as health conditions.
5. Because of increased availability of specialized instruction and special classes for some children with learning or other disabilities, the activity limitation questions for the school-age population now include specific reference to both the use of and need for these programs.

Note: Because of administrative error, no activity limitation estimates are available for 1982.

Disability-related interview questions are listed below.

#### Limitation of Activity?

Unable to carry on major activity  
Limited in amount or kind of major activity  
Not limited in major activity but otherwise limited  
Not limited in activities

#### Duration of Limitation of Activity?

Month/years.

Primary and secondary cause of limitation of activity (International Classification of Diseases, 9th Revision).

International Classification of Diseases (9th Revision) codes are also grouped into one of the following:

The International Classification of Diseases (ICD) codes assigned to every reported condition were edited for the first time in 1982. As expected, the edits resulted in additional rejected condition records.

Major Condition Categories: circulatory; respiratory; digestive; skin and musculoskeletal; genitourinary; nervous; endocrine, metabolic and blood forming systems; other.

Major Impairment Categories: visual impairments; hearing impairments; speech impairments; sensory impairments; mental retardation; absence of extremities; complete/partial paralysis; deformity/orthopedic impairments; other.

#### Family Composition

Type of Family: primary individual, secondary individual, primary family, secondary family.

Relationship: unrelated individual living alone, head of family or unrelated individual not living alone, wife (husband living at home and *not* in Armed Forces), wife (husband living at home and *is* in Armed Forces), child of head or of spouse of head, grandchild of head or of spouse of head, parent of head or of spouse of head, other relative.

Relationship Recode: living alone, living with nonrelative, living with spouse, living with other relative.

Actual Family Size: Number of family members.

Size of Family Recode: unrelated individuals, 1 member, 2 members, 3 members, 4 members, 5 members, 6 members, 7 members, 8 or more members.

Family Structure (for persons age 21-24): both parents, no other adult; mother only; father only; both parents and other adult relative; mother and other adult relative; father and other adult relative; no parent, but one adult relative; no parent, but two or more adult relatives; other; not applicable (25 + years and/or ever married).

#### Beneficiary Status for Major Federal Programs

Medicaid, Medicare, public assistance, Veterans pension or other military benefits, Aid to Families with Dependent Children, Supplemental Security Income.

#### Other Health Related Data

Reported.

#### Other Demographic Data

Sex, education, marital status.

#### Geographical Area

State:

Not reported.



Region:

Northeast, North Central, South, West.

SMSA:

Thirty-one largest SMSA's reported.

#### Service Utilization

##### Types of Services

Doctors, dentists, hospitals.

##### Level of Utilization

Reported.

#### AVAILABILITY OF DATA

##### Price of Data or Tapes

1981: \$530.

Accession number: PB84-111657/HAI

1982: \$535.

1983: \$610.

##### User Representative

National Center for Health Statistics  
Division of Health Interview Statistics  
Center Building Room 2-44  
3700 East-West Highway  
Hyattsville, MD 22161  
(703) 487-4650

Order Point:

National Technical Information Service  
5285 Port Royal Road  
Springfield, VA 22161  
(703) 487-4650

#### TAPE CHARACTERISTICS

##### Density

1600 bpi.

##### Number of Tracks

Nine.

##### Magnetic Recording Codes

EBCDIC.

##### Preformatted

No.

##### Data Structure

Multiple rectangular files.

##### Technical Documentation

Beane, Judy A. *Estimate and Sampling Variance in the Health Interview Survey*. Vital and Health Statistics Series 2 - 38, June 1970.

*Public Use Data Tape Documentation - Part I, Interview Manual, National Health Interview Survey*. Hyattsville, MD: National Center for Health Statistics, September 1983.

*Public Use Data Tape Documentation - Part II, Interview Manual, National Health Interview Survey*. Hyattsville, MD: National Center for Health Statistics, September 1983.



Health Interview Survey Procedure, 1957-1974. *Vital and Health Statistics*. Series 1-No. 11, April 1975. DHEW Pub. No. (HRA) 75-1311.

*Health Information Survey Medical Coding Manual and Short Index*. Hyattsville, MD: National Center for Health Statistics, 1979.

## **SURVEY EVALUATION**

### **Narrative Assessment**

Limited sample size and corresponding sampling error prohibit analyses of the characteristics of disabled persons by category of disabling condition for single years of data.

### **Prior Users and Use Reports**

Black, E.R. Use of Special Aids, United States, 1977. *Vital and Health Statistics*, 10 (135), October 1980.

Bloom, B. Current Estimates from the National Health Interview Survey: United States, 1981. *Vital and Health Statistics*, 10 (141), October 1982.

Feller, B. Americans Needing Help to Function at Home. *Advancedata*, 92, September 14, 1983.

Feller, B. Health Characteristics of Persons with Chronic Activity Limitation: United States, 1979. *Vital and Health Statistics*, 19 (137), December 1981.

Feller, B. Prevalence of Selected Impairments: United States, 1977. *Vital and Health Statistics*, 10 (134), February 1981.

Ries, P. Hearing Ability of Persons by Socio-Demographic and Health Characteristics: United States. *Vital and Health Statistics*, 10 (140), August 1982.

Wilder, Charles. Disability Days: United States. *Vital and Health Statistics*, 10 (143), July 1983.

# **NATIONAL INTERVIEW SURVEY OF PUBLIC AND COMMUNITY RESIDENTIAL FACILITIES FOR MENTALLY RETARDED PERSONS**

## **CONTACT**

Bradley Hill  
Center for Residential and Community Services  
207 Pattee Hall  
150 Pillsbury Drive, SE  
University of Minnesota  
Minneapolis, MN 55455  
(612) 624-7337

## **SPONSOR**

Administration on Developmental Disabilities, Office of Human Development Services, U.S. Department of Health and Human Services.

## **PERIOD**

1978, 1979.

## **SURVEY DESCRIPTION**

### **Survey Objectives**

To provide information on changing patterns of residential services for persons who are mentally retarded.

### **Populations Surveyed**

Persons residing in a state sponsored and administered facility which offers comprehensive programming on a 24-hour, 7 days-a-week basis or in any community-based living quarters which provide 24-hour, 7 days-a-week responsibility for room, board, and supervision of mentally retarded

persons with the exception of (a) single family homes providing services to a relative; (b) nursing homes, boarding homes, and foster homes that are not formally state licensed or contracted as mental retardation service providers; and (c) independent living (apartment) programs which have no staff residing in the same facility; as of June 30, 1977.

### Survey Size

	Residents as of June 30, 1977	New Admissions	Readmissions	Persons Released
Public Residential Facilities	983	220	210	497
Community Residential Facilities	1,024	Not sampled	Not sampled	Not sampled

### Survey Design

This is a two-stage probability sample with partial replacement. In the first stage, a sample of 78 public and 180 community residential facilities are selected so that the probability of selection is proportionate to the number of mentally retarded residents and so that the distribution of sample facilities across census regions and size classes is in close agreement with the distribution of the national resident population. The second stage involves random selection of residents within sampled facilities. Within public residential facilities three additional samples are selected: new admissions, readmissions and residents released during particular time periods during 1977 and 1978.

### Data Source

Demographic information about individual residents is obtained from each resident's records and recorded on a Personal Record Sheet. Other information about residents is obtained by interview using a structured questionnaire with

direct care staff persons most directly involved with the residents' day-to-day care for at least two months prior to the survey.

### Estimation (Case Weighting) Scheme

The estimation procedure consists of inflating the sample counts by the reciprocal of the probabilities of selection. Specific weighting procedures vary across subject areas and by type of analysis.

### Response Rates

#### *Number and Percent of Residents Responding by Facility Type*

	Current Residents		New PRF Admissions		PRF Re- admissions		Released PRF Residents	
Public Residential Facilities (PRF's)	953	96.9%	211	95.9%	192	91.4%	478	96.2%
Community Residential Facilities (CRF's)	965	94.2%	N/A		N/A		N/A	

### Treatment of Missing Values

Missing values are shown as such.

### Sampling Error

Approximate relative standards errors:

	Sex	Level of Retardation	Ambulatory
PRF's	2.3%	1.3 - 2.4%	1.7%
CRF's	2.5%	1.9 - 2.5%	2.8%

## KEY VARIABLES AND VARIABLE BREAKDOWNS

### Age

Age in years.

### Race/Ethnicity

White, Black, Hispanic, American Indian or Alaskan, Asian or Pacific Islander.

### Family Income

Not reported.

### Employment Status

Not reported.

### Rural/Urban Residence

Not reported.

### Disabling Conditions/Functional Limitations

Degree of retardation from most recent evaluation: Borderline (IQ 69–84), Mild (IQ 52–68), Moderate (IQ 36–51), Severe (IQ 20–35), Profound (IQ 19 and below), unknown.

In addition to evidence of his or her mental retardation, do the records show autism or mental illness of any kind?

Besides being mentally retarded, does (Resident) have any of these other disabilities: deaf or hearing impaired, blind or visually impaired, cerebral palsy, other physical handicap (what kind?), anything else (what?)?

Which of these best describes how well (he/she) hears (with/without) a hearing aid: no difficulty, can hear most of the things a person says; great difficulty; can hear only a few words said or loud noises; deaf or no usable hearing; don't know?

Which of these describes how well (he/she) sees (with/without) glasses: no difficulty seeing; some difficulty in seeing but can see television size images from 8 to 10 feet away; great difficulty in seeing but sees enough to walk around without usually bumping into things; blind or no usable vision; don't know?

How would you describe how (he/she) *usually* gets around at (Facility): walks with no problems; walks unsteadily or awkwardly without assistance; walks with assistance of cane, crutches, walker or another person; propels self in wheelchair or operates own motorized wheelchair; crawls or creeps; confined to bed, crib or mat; other (describe)?

How would you best describe (Resident's) hand and arm use: has complete control in using hands and arms for activities appropriate to his/her age; has some inability to use hands or arms, but can manage most activities independently; needs a good deal of help and/or use of adaptive equipment to use hands and arms; has little or no useful hand or arm control?

Which of these best describes the way (Resident) *usually* communicates with other people: talks; uses sign language; points, types or writes instead of talking; uses a symbol system; points or uses gestures; may cry or smile, but otherwise unable to communicate; other (specify)?

How easily can the (words/signs) be understood by the average person (who knows sign language): easily understood, somewhat difficult to understand (can usually be understood, but has difficulty with some words or signs), hard to understand (can be understood only with difficulty, usually cannot be understood well by a stranger)?

### Family Composition

Not reported.

### Beneficiary Status for Major Federal Programs

Not reported.

## Other Health Related Data

Not reported.

## Other Demographic Data

Sex, height, weight, age, previous placement, length of stay.

## Geographical Area

State:

Not reported.

Region:

Northeast, North Central, South, West.

SMSA:

Not reported.

## Service Utilization

### Types of Service

Individual Program Plans; special education classes; supported employment/day activities; dental and medical services; mental health services; physical, occupational and speech therapy; transportation.

### Level of Utilization

Reported.

## AVAILABILITY OF DATA

Tapes will be available in the near future.

### Price of Data or Tapes

\$1,000 tapes  
\$200 codebook

## User Representative

Bradley Hill  
Center for Residential and Community Services  
207 Pattee Hall  
150 Pillsbury Drive, SE  
University of Minnesota  
Minneapolis, MN 55455  
(612) 624-7337

## TAPE CHARACTERISTICS

### Density

1600 bpi.

### Number of Tracks

Nine.

### Magnetic Recording Codes

EBCDIC or ASCII.

### Preformatted

SPSS.

### Data Structure

The data are in SPSS system files, but could be written into rectangular files.

### Technical Documentation

Hauber, F., Bruininks, R., Wieck, C., Sigford, B., and Hill, B. *1978-1979 In-Depth National Interview Survey of Public and Community Residential Facilities for Mentally Retarded Persons: Methods and Procedures*. Minneapolis: Center for Residential and Community Services, 1981.

Hess, I. *Sample Design for the Study of United States Public Residential Facilities for Mentally Retarded, 1978-1979*. Ann Arbor,

MI: Survey Research Center, 1979. Unpublished manuscript.

Hill, B., and Bruininks, R. *Behavioral Characteristics Assessment: Technical Manual* (Developmental Disabilities Project on Residential Services and Community Adjustment Working Paper No. 3). Minneapolis: Department of Psychoeducational Studies, University of Minnesota, 1980. Unpublished manuscript.

## **SURVEY EVALUATION**

### **Narrative Assessment**

There is a sample bias in that Community Residential Facilities with more than 400 residents are under represented.

### **Prior Users and Reports**

None to date.

## **NATIONAL LONGITUDINAL SURVEYS (NLS)**

### **CONTACT**

Gale James  
NLS Users Office  
Center for Human Resource Research  
650 Ackerman Road, Suite A  
Columbus, Ohio 43202  
(614) 263-1682

### **SPONSOR**

U.S. Department of Labor.

### **PERIOD**

Annually or biannually (depending upon the schedule for each panel) since 1966. The newest "Youth Cohort" began in 1979. The Survey of Older Men and Survey of Young Men (see "Population Surveyed" below) are discontinued as of 1983 and 1981 respectively.

## **SURVEY DESCRIPTION**

### **Survey Objectives**

To gather indepth information on labor and market experiences of adult men and women, and youth.

### **Population Surveyed**

Five separate cohorts are surveyed:

- (1) Civilian men who were ages 45 to 59 in 1966 (Survey of Older Men);
- (2) Civilian women who were ages 30 to 44 in 1967 (Survey of Mature Women);



- (3) Civilian men who were ages 14 to 24 in 1966 (Survey of Young Men);
- (4) Civilian women who were ages 14 to 24 in 1968 (Survey of Young Women);
- (5) Civilian and military men and women who were ages 14 to 21 in 1979 (Survey of Youth).

### Survey Size

- Cohorts 1-4: Approximately 5,000 respondents per cohort.
- Cohort 5: Approximately 12,700 respondents.

### Survey Design

Each of the first four age-sex cohorts is represented by a multi-stage probability sample located in 235 sample areas comprising 485 counties and independent cities representing every state and the District of Columbia. The 235 sample areas are derived by grouping all of the nation's counties and independent cities into about 1,900 primary sampling units (PSU's) and further forming 235 strata of one or more PSU's that are relatively homogeneous with respect to socioeconomic characteristics. Within each of the strata a single PSU represents the stratum. Within each PSU a probability sample of housing units is selected to represent the civilian noninstitutionalized population. To provide separate reliable statistics for blacks, households in predominately black enumeration districts (ED's) are represented at a rate between three and four times that for households in predominantly white ED's.

The fifth cohort targets ten different race-sex-military status groups. With the exception of individuals on active military duty, all sample selection is accomplished through a multi-stage, stratified area probability sample of dwelling units and group quarter units. Minority and economically disadvantaged groups are slightly oversampled. Members on active military duty are sampled in two stages from rosters provided by the Department of Defense. In the first stage, a

sample of approximately 200 "military units" is selected, with probabilities proportional to the number of persons 14-21 within the unit. In the second stage, persons 14-21 are subsampled with probabilities inversely proportional to the first-stage selection probability.

### Data Source

Mail survey, telephone, and personal interviews.

### Estimation (Case Weighting) Scheme

Individual case weights are assigned to base year interviews in such a way as to produce group population projections. Weighting occurs in three stages:

- (1) Weighting by the reciprocal of the probability of selection;
- (2) Adjusting for differential response rates in both the screening phase and baseline interviews;
- (3) Adjusting for random variation associated with sampling and sample "undercoverage," a ratio estimation used to conform the sample to independently derived population totals.

### Response Rates

#### *Percentage of Original Respondents Participating as of 1983*

<i>Cohort</i>	<i>Percent</i>
Older Men	52.3
Mature Women	69.7
Young Men	64.9
Young Women	68.7
Youth (Men)	96.0
Youth (Women)	96.7



## Treatment of Missing Values

Missing values are coded as missing and retained in the data set.

## Sampling Error

Not available.

## KEY VARIABLES AND VARIABLE BREAKDOWNS\*

### Age

Older Cohorts:

Age in years as of date of interview.

Date of birth.

Youth Cohort:

Same as above.

### Race/Ethnicity

Older Cohorts:

White, Black, other.

Youth Cohort:

Race: White, Black, Hispanic.

Ethnicity: Up to six ethnic affiliations are coded for each respondent from a list of approximately thirty different categories of ethnic origin.

## Family Income

Older Cohorts:

In dollar amounts up to a certain cap, depending upon the year. Currently the cap is \$75,000.

Youth Cohort:

Same as above.

## Employment Status

Older Cohorts:

Reported.

Youth Cohort:

Reported.

## Rural/Urban Residence

Older Cohorts:

In SMSA, in central city, out of SMSA.

Youth Cohort:

Same as above.

More detailed geographic information is available on a separate geocode tape that may be purchased if the purchaser signs a statement assuming liability in the event that individuals can be identified using the data from the geocode and main tapes.

## Disabling Conditions/Functional Limitations

Older Cohorts (baseline questionnaire):

For persons not working and not looking for work:

---

\*Generally variables are coded similarly for the four older cohorts. In some cases the youth data are significantly different, so variable breakdowns will be reported separately for each of these two groups. In addition, items may vary slightly depending on the survey year.

If respondent had previous job: Why did you leave that job? Seven response categories including "health."

Does your health or physical condition

Keep you from working?  
Limit the kind of work you can do?  
Limit the amount of work you can do?

In what way are you limited?  
How long have you been limited in this way?

Would you rate your health, compared with other men of about your age, as excellent, good, fair or poor?

Does your wife's health or physical condition

Keep her from working?  
Limit the kind of work she can do?  
Limit the amount of work she can do?  
Limit the amount or kind of housework she can do?

In what way is she limited?  
How long has she been limited in this way?

Older Cohorts (subsequent questionnaires):

For weeks unaccounted for in work history since last interview:

What would you say was the main reason you were not looking for work? Five response categories including "ill or disabled and unable to work."

The following questions are asked only for selected interview years:

Would you say your health or physical condition now is better, about the same, or worse than a year ago?

Has this change had any effect upon the kind or amount of work you can do?

Repeat of previous questions for respondent's wife.

Youth Cohort:

For persons not employed: What are the reasons you [do not want a job] [are not looking for work]? Fourteen response categories including "ill health, physical disability."

1979 baseline questionnaire:

For respondents who did not have a job during the week prior to interview:

Would your health keep you from working *on a job for pay* now?

Are you/would you be limited in the *kind* of work you (could) do on a job for pay because of your health?

Are you/would you be limited in the *amount* of work you (could) do because of your health?

Since what month and year have you had this limitation? (Month, year/if volunteered—"all of my life").

What health condition causes you to be limited in work?

If more than one condition: Which of these health conditions would you say is the *main* cause of your limitation in work?

Since what month and year have you had this condition (month, year/if volunteered—"all my life").

Condition is coded according to the International Classification of Diseases, 9th revision.

Condition is coded as one of 34 health/disease categories (e.g., acne, epilepsy, mumps, etc.) OR accident or injury, OR normal pregnancy, delivery, vasectomy, or tubal ligation.

Condition is also coded as cancer OR one of 34 health/disease categories (see above) OR neither.

Condition is coded in several other groups of medical categories.

When did you first notice the condition?

Date and effects of accidents are recorded.

## **Family Composition**

Older Cohorts:

A complete list of everyone in the household and their relationship to the respondent is available.

Total number of family members.

Total number of household members.

Youth Cohort:

Same as above.

## **Beneficiary Status for Major Federal Programs**

Older Cohorts:

Unemployment, Social Security, Veterans Administration compensation or pension, workers' compensation, Aid to the Aged, Blind and Disabled, Aid to the Permanently and Totally Disabled, public assistance or welfare, Government pensions (local, state, federal).

Youth Cohort:

Unemployment, Aid to Families with Dependent Children, food stamps, Supplemental Security Income, public assistance or welfare, GI Bill or Veterans Educational Assistance Program, Social Security.

## **Other Health Related Data**

Older Cohorts:

Not reported.

Youth Cohort:

Reported.

## **Other Demographic Data**

Older Cohorts:

Sex, marital status, education.

Youth Cohort:

Sex, marital status, education, religion.

## **Geographical Area**

**State**

Older Cohorts:

Not reported.

Youth Cohort:

Reported only on the geocode tape (see "Rural/Urban Residence" above).

**Region**

Older Cohorts:

North, South.

#### Youth Cohort:

A number of regional categories can be derived using the geocode tapes (see "Rural/Urban Residence" above).

#### SMSA

##### Older Cohorts:

In/out of SMSA. Specific SMSA's cannot be identified.

##### Youth Cohort:

Same as above. Specific SMSA's can be identified with geocode tape (see "Rural/Urban Residence" above).

#### Service Utilization

##### Types of Services

##### Older Cohorts:

Not reported.

##### Youth Cohort:

Doctor.

##### Level of Utilization

Not reported.

#### AVAILABILITY OF DATA

Tapes and technical documentation for all five cohorts are available for purchase. Data tapes for the Youth cohort are organized into 40 subject-related extract files due to the size of the data set. This organization provides a great deal of flexibility to users, but also requires careful consideration when ordering less than the entire data set.

#### Price of Data or Tapes

This depends upon the numbers of tapes ordered. For example, all data for the older four cohorts plus documentation may be purchased for \$300 at 1600 bpi, or \$250 at 6250 bpi (Older Men, 1966-1983; Mature Women, 1967-1984; Young Men, 1966-1981; Young Women, 1968-1984). Youth cohort data are available for:

Single year files	\$100 each
Extract files	\$65 - \$150 (estimate)
Complete survey 1979-1984 (5 years)	\$300

#### User Representative

Gale James  
NLS Users Office  
Center for Human Resource Research  
650 Ackerman Road, Suite A  
Columbus, Ohio 43202  
(614) 263-1682

#### TAPE CHARACTERISTICS

##### Density

1600 or 6250 bpi.

##### Number of Tracks

Nine.

#### Magnetic Recording Codes

##### Older Cohorts:

EBCDIC, IBM.

##### Youth Cohort:

EBCDIC, ASCII.

## Preformatted

No.

## Data Structure

Older Cohorts:

Rectangular.

Youth Cohort:

Multiple rectangular files.

## Technical Documentation

Furnished with tapes are:

- codebook
- *NLS Handbook*
- interview schedules
- interviewers' reference materials
- variable indexes

Also available:

Rhoton, Patricia. *Attrition and the National Longitudinal Surveys of Labor Market Experience: Avoidance Control and Correction*. Columbus: Center for Human Resource Research, The Ohio State University, February 1984. Prepared for the U.S. Department of Labor.

## SURVEY EVALUATION

### Narrative Assessment

These surveys provide a rich source of data on the work experiences of individuals over an extended period of time. Unfortunately, parallel questions for all cohorts and all years on health and disability are not asked, making it difficult to examine the course of individual disabilities over time. Furthermore, disability is assessed only to the extent that work is affected, and is asked as a general question. Only

in the youth cohort data set are more detailed items included on disabling conditions and their severity and duration.

### Prior Users and Use Reports

An annotated bibliography of all known uses of NLS data identified by the Center for Human Resources Research up to 1984 is available for \$20.00 from the Center. An update is available for \$3.00. The *NLS Handbook*, which is designed to answer the most frequently asked questions, is available free of charge.

# NATIONAL MEDICAL CARE UTILIZATION AND EXPENDITURE SURVEY (NMCUES) (1980)

## CONTACT

Michelle Chyba  
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Division of Health Interview Statistics  
National Center for Health Statistics  
Hyattsville, MD 20782  
(301) 436-7100

## SPONSOR

National Center for Health Statistics and Health Care Financing Administration.

## PERIODS

Early 1980 to early 1981.

## SURVEY DESCRIPTION

### Survey Objectives

To obtain statistical information on health care status, patterns of health care utilization, charges for services received, and methods of payment in the contiguous United States.

### Population Surveyed

This file contains two separate surveys. The national household survey draws from the civilian noninstitutionalized population. Noninstitutionalized Medicaid eligible persons constitute the survey population for a four state Medicaid Survey.

## Sample Size

The national household survey is comprised of approximately 6,600 households with 17,600 individuals. The four state Medicaid samples (New York, California, Michigan and Texas) consist of 4,000 households with 13,400 persons.

## Sample design

The design involves two surveys: A sample survey of national households and sample survey of Medicaid households in four states.

**National household sample:** The national sample consists of two separate multistage area probability samples of housing units and group quarters, selected with a known and approximately equal probability. The sample frames are based on 1970 census counts, updated for new construction and checked by interviewers in the field. All persons living in the housing units or group quarters at the time of the first interview contact are part of the sample.

**State Medicaid household samples:** The November 1979 Medicaid eligibility files in California, Michigan, New York, and Texas are used to draw samples of cases for the state Medicaid household survey. A case generally consists of all members of a family receiving Medicaid within the same category of aid. The state aid categories are collapsed into three or four strata, depending on the State. These are: (1) aid to the blind and disabled, (2) aid to the elderly (those with Supplemental Security Income), (3) Aid to Families with Dependent Children (AFDC), and (4) state only aid in California, Michigan, and New York (those states provide some Medicaid coverage without Federal reimbursement). Approximately equal numbers of cases are selected from each stratum, and cases are clustered within zipcodes for ease of interviewing. Interviewers obtain information for the eligible members in each case. Persons included in the sample are grouped into "reporting units" which are defined as all persons related to the head of household and living in the same housing unit or group quarters.



## Data Source

Five rounds of data collection including two personal interviews, two telephone interviews, and a final personal interview. Each round of interviews is approximately three months apart.

## Estimation (Case Weighting) Scheme

Cases are weighted to adjust for the potential biasing effects of nonresponse and sampling undercoverage. Undercoverage results from an incomplete listing of housing units from which the housing unit sample is drawn and the tendency to omit persons who have no usual place of residence.

A two step weight adjustment process is adopted to account for nonresponse or undercoverage for (1) an entire reporting unit (household) and for (2) individuals within a reporting unit (RU).

The initial weight associated with each RU is the inverse of its sample selection probability. These rates are then ratio adjusted to 1980 Current Population Survey estimates of the number of RU equivalents. Initial weights of the responding persons are ratio adjusted to estimates of the size of the eligible population based upon the 1980 Decennial Census.

## Response Rates

There is a 90 percent response rate to the initial household survey. Overall there is a 5 percent attrition rate of originally responding sample members.

## Treatment of Missing Values

Data are imputed for respondents who provide data for only a portion and not the whole of one year. Data are imputed from full-year respondents with similar characteristics. Missing questionnaire items are imputed logically when the other data provided give a good indication of the appropriate response. If this is not possible an item is statistically im-

puted by assigning a value from a responding person with similar characteristics.

## Sampling Error

Standard error tables are available for selected variables. Examples are given below.

1,470 persons in the sample who are 65 years of age or over living in the community and reporting some limitation of activity, standard error: 237.6.

2,047 persons in the sample who are 65 years of age and over living in the community and reporting unable to perform usual activity, standard error: 104.3.

## KEY VARIABLES AND VARIABLE BREAKDOWNS

### Age

Age is computed from the birthdate.

### Race/Ethnicity

Race: American Indian or Alaskan, Asian or Pacific Islander, Black, White.

Hispanic Origin: Not Hispanic, Puerto Rican, Mexican or Mexican American, other.

### Family Income

Less than \$3,000; 3,000-4,999; 5,000-6,999; 7,000-9,999; 10,000-11,999; 12,000-14,999; 15,000-19,999; 20,000-24,999; 25,000-34,999; 35,000 and over.

### Employment Status

Not reported.

## Disabling Conditions/Functional Limitations

Acute conditions and chronic conditions according to the International Classification of Diseases, Ninth Revision as adapted for use with household surveys by the National Center for Health Statistics.

Functional limitation of ability to perform daily activities (i.e., trouble with mobility, motor functions, self help skills); degree of functional limitations (code on a scale 1-8: 1 = no limitation, 2 = minimal limitation, . . . 8 = most severe limitation); medically unattended conditions; disabling conditions (condition is assigned an International Classification of Disease code number); degree of limitation of activity (coded as: cannot perform usual activity, limited in amount or kind of usual activity, limited in outside activities, not limited); condition causing limitations; number of work days lost; number of bed disability days due to main condition.

## Family Composition

Relationship of persons in reporting unit to head of household. Number of persons in reporting unit. Changes in reporting unit composition during course of survey.

## Beneficiary Status for Major Federal Programs

Veterans payments, Veterans service connected disability, Medicare, Medicaid, CHAMPUS, Indian health coverage, unemployment, workers' compensation, Social Security, Supplemental Security Income.

## Other Health Related Data

Reported.

## Other Demographic Data

Sex, marital status, education, Veteran status, health insurance coverage.

## Geographical Area

State:

States (New York, California, Michigan and Texas) are shown for the state specific Medicaid survey only.

Region:

Northeast, North Central, South, West.

SMSA:

SMSA central city, not central city; non-SMSA urban or rural.

## Service Utilization

### Types of Services

Services are reported for each reported "health event," where a health event could be a hospital stay, emergency room use, hospital outpatient visit, doctor or dental visit, prescribed medicine, or other medical expense. Services may include orthopedic items, hearing aids or other special equipment.

### Level of Utilization

Reported.

## AVAILABILITY OF DATA

Presently data tapes and documentation are available only for the household survey and its corresponding administrative records review. They are not available for the state Medicaid survey. Data tapes and documentation are being prepared for the state Medicaid survey to be distributed through the National Technical Information Service; they are to be ready by mid-1986.

## Price of Data or Tapes

6250 bpi: \$370.  
1600 bpi: \$610.

Documentation for tapes comes with the tape purchase or can be ordered separately from the sales desk of the National Technical Information Service (703) 487-4600. Refer to document numbers PB 83260406 and PB 83260398.

## User Representative

Michelle Chyba  
Utilization and Expenditure Statistics Branch  
Division of Health Interview Statistics  
National Center for Health Statistics  
Hyattsville, MD 20782  
(301) 436-7100

### Order Point:

National Technical Information Service  
Computer Products  
5285 Port Royal Road  
Springfield, VA 22161  
(703) 487-4763  
Order No. PB 83229542

## TAPE CHARACTERISTICS

### Density

1600 or 6250 bpi.

### Number of Tracks

Nine.

### Magnetic Recording Code

EBCDIC.

## Preformatted

No.

## Data Structure

Rectangular.

## Technical Documentation

*Public Use Data Tape Documentation, National Medical Care Utilization and Expenditure Survey, 1980*, Washington: National Center for Health Statistics, August 1983.

Bonham, G.S. *Procedures and Questionnaires of the National Medical Care Utilization and Expenditure Survey, Series A*, Methodological Report, No. 1. Washington: National Center for Health Statistics, March 1983.

## SURVEY EVALUATION

### Narrative Assessment

The data file contains statistics on medical care utilization and expenditures by disabled persons; however, the sampling error is relatively high, thus limiting the reliability and utility of these figures.

### Prior Users and Use Reports

Bonham, G.S. Dental Care Charges, United States, January-June 1980. *National Medical Care Utilization and Expenditure Survey*, Preliminary Data No. 1. Washington: National Center for Health Statistics, April 1982.

Bryant, E.D., and Biggar, R. Utilization and Expenditures for Ambulatory Medical Care by People Hospitalized, United States, 1980. *National Medical Care Utilization and Expenditure Survey, Series B, Descriptive Report No. 7*. Washington: National Center for Health Statistics, April 1985.

Chyba, M.M. Utilization of Hospital Emergency and Out-patient Departments, United States, January-June, 1980.

*National Medical Care Utilization and Expenditure Survey, Preliminary Data Report No. 2.* Washington: National Center for Health Statistics, February 1983.

Dicker, M. Health Care Coverage and Insurance Premiums of Families, United States, 1980. *National Medical Care Utilization and Expenditure Survey, Data Report No. 3.* Washington: National Center for Health Statistics, May 1983.

Kovar, M.G. Expenditures for the Medical Care of Elderly People Living in the Community throughout 1980. *National Medical Care Utilization and Expenditure Survey, Data Report No. 4.* Washington: National Center for Health Statistics, November 1983.

Mugge, R.H. Persons Receiving Care from Selected Health Care Practitioners, United States, 1980. *National Medical Care*

*Utilization and Expenditure Survey. Series B, Descriptive Report No. 6.* Washington: National Center for Health Statistics, September 1984.

Schlenger, W., Wadman, W., and Corder, L. Health Status of Aged Medicare Beneficiaries. *National Medical Care Utilization and Expenditure Survey. Series B, Descriptive Report No. 3.* Washington: Health Care Financing Administration, April 1984.

Taube, C.A., Kessler, L., and Feuerberg, M. Utilization and Expenditures for Ambulatory Mental Health Care during 1980. *National Medical Care Utilization and Expenditure Survey, Data Report No. 5.* Washington: National Center for Health Statistics, June 1984.

# NATIONAL MULTIPLE SCLEROSIS SURVEY

## CONTACT

Dallas Anderson, Ph.D.  
Office of Biometry and Field Studies  
National Institute of Neurological and  
Communicative Disorders and Stroke  
National Institutes of Health  
Bethesda, MD 20892  
(301) 496-3256

## SPONSOR

National Institute of Neurological and Communicative  
Disorders and Stroke (NINCDS).

## PERIOD

January 1, 1970 - December 31, 1975.

## SURVEY DESCRIPTION

### Survey Objectives

This is one of several surveys to meet NINCDS's need for accurate health statistics. The chief goal of these surveys is to obtain precise national estimates of the incidence, prevalence, and economic costs of selected disorders. These estimates are needed to set priorities, to help allocate health resources, and to assist in regulatory and planning efforts.

### Population Surveyed

U.S. patients treated by physicians or in hospitals in the contiguous United States.

### Survey Size

1,200 patients interviewed (identified through 8,800 physicians and 725 hospitals).

## Survey Design

The survey involves a two-stage sampling procedure. In the first stage, a probability sample of 8,800 physicians and 725 hospitals, located in the contiguous United States, is drawn from the universe of physicians and hospitals considered most likely to treat multiple sclerosis patients.

In the second stage the selected doctors and hospitals supply information on the numbers, demographics and disease characteristics of multiple sclerosis patients that they treated between January 1970 and December 1975. A probability sample of the identified cases is drawn and selected patients interviewed.

## Data Source

Personal interviews with patients or relatives (direct). Respondents are interviewed on two occasions about three months apart. During the interviewing period patients keep diaries of their medical care expenditures. Initial interviews are completed in person while followup interviews are conducted by telephone.

## Estimation (Case Weighting) Scheme

The methods used to estimate prevalence and incidence of multiple sclerosis are essentially the same. However, unlike estimates of prevalence, estimates of incidence include information on persons deceased during the reporting period. This is possible because the key variable involved in incidence is the date of diagnosis.

Independent estimates of (1) the prevalence and (2) the incidence of multiple sclerosis are generated through the use of two separate estimating procedures. The first procedure is based on data supplied by providers. The second procedure relies on data supplied by patients. Details of how each procedure is carried out are described in *Estimating Incidence and Prevalence* (1970). (See Prior Users and Prior Use Reports below.) Both methods include the following weights:



Ratio adjusting the number of patients treated by the provider sample to the total multiple sclerosis population;

adjusting for estimated duplicate mentions of the same patient within this count;

adjusting for nonresponse.

#### **Response Rates**

Approximately 99 percent of the physicians responded with information on the number of multiple sclerosis patients they treated during the survey period. Seventy-five percent of these provided the requested data on each case seen during the interval. Corresponding response rates from the hospitals were 93 percent and 90 percent.

The response rate for patients was 76 percent, yielding 1,241 interviews. Of these, 1,145 patients were alive as of the prevalence date, January 1, 1976.

#### **Treatment of Missing Values**

Missing items on individual records are coded as missing and are not identified in tabulations of data.

#### **Sampling Error**

The estimated prevalence of multiple sclerosis on January 1, 1976 is 123,000 cases. A 95 percent confidence interval is calculated as 106,000 to 140,000.

In calculating the standard error, two elements of variability are considered. The first element is the variance of the estimate of the duplicated patient file. Second, the variance of the duplication estimate is calculated. Replicated sampling methods are used to derive the duplication estimate and to estimate the variance on the estimate.

### **KEY VARIABLES AND VARIABLE BREAKDOWNS\***

#### **Age**

Less than 20 years, 20-29, 30-39, 40-49, 50-59, 60 and over.

#### **Race/Ethnicity**

White, nonwhite.

#### **Family Income**

Not reported.

#### **Employment Status**

Reported.

#### **Rural/Urban Residence**

Not reported.

#### **Disabling Conditions/Functional Limitations**

Assistance needed for mobility: indoors and outdoors, outdoors only.

Use of a specific appliance for mobility (i.e., crutches, leg braces, walkers and canes, wheelchairs, assistance of another person).

Common symptoms of multiple sclerosis: weakness, numbness, difficulty with coordination, loss of balance, vision problems, loss of bladder or bowel control, speech problems, dizziness (vertigo).

#### **Family Composition**

Not reported.

\*Reported as available in published documents (see "Prior Users and Use Reports" below).



## Beneficiary Status for Major Federal Programs

Not reported.

## Other Health Related Data

Reported.

## Other Demographic Data

Sex.

## Geographical Area

State:

Not reported

Region:

Above or below 37th parallel.

SMSA:

Not reported.

## Service Utilization

### Types of Services

Type of health care provider who first diagnosed multiple sclerosis: physician, hospital.

### Level of Utilization

Not reported.

## AVAILABILITY OF DATA

No tapes are available; however a summary of findings may be obtained.

## User Representative

Dallas Anderson, Ph.D.

Office of Biometry and Field Studies

National Institute of Neurological and Communicative Disorders and Stroke

National Institutes of Health

Bethesda, MD 20892

(301) 496-3256

## SURVEY EVALUATION

### Narrative Assessment

This survey provides useful baseline data on the incidence, prevalence and common symptoms of multiple sclerosis. However, disability and functional limitation data are limited to published materials which do not provide comprehensive data.

### Prior Users and Use Reports

*Estimating Incidence and Prevalence. National Study of Multiple Sclerosis.* Philadelphia: National Analysts, a Division of Booz, Allen and Hamilton, Inc., August 1979.

*Multiple Sclerosis: A National Survey.* Washington: Public Health Service, September 1984.

Baum, H.M. and Rothschild, B.B. The Incidence and Prevalence of Reported Multiple Sclerosis. *Annals of Neurology*, 10 (5), 420-428, 1981.

Baum, H.M. and Rothschild, B.B. Multiple Sclerosis and Mobility Restrictions. *Archives of Physical Medicine and Rehabilitation*, 64, 591-596, 1983.

Inman, R. Disability Indices, the Economic Cost of Illness, and Social Insurance: The Case of Multiple Sclerosis. *Acta Neurologica Scandinavica*, 70 (101), 46-55, 1984.

Kornblith, A.B., La Rocca, N.G., and Baum, H.M.  
*Employment in Individuals with Multiple Sclerosis*. To Appear  
in the *International Journal of Rehabilitation Research*.

## NATIONAL NURSING HOME SURVEY (NNHS)

### CONTACT

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(301) 436-8830

### SPONSOR

National Center for Health Statistics.

### PERIOD

May-December 1977.

### SURVEY DESCRIPTION

#### Survey Objectives

The 1977 NNHS was the second of a series of surveys designed to provide information to policy makers, planners, researchers, and those who establish standards for long term care services. The first survey was conducted from August 1973 through April 1974 and was limited to nursing homes. The 1977 survey includes a broader population of long term care institutions.

#### Population Surveyed

Residents, discharges, and employees from two groups of homes are surveyed: (1) those classified as nursing homes in the 1973 National Master Facility Inventory (NMFI), and (2) nursing homes opened for business since 1973. The NMFI is a census of all inpatient health facilities conducted every two to three years by the National Center for Health Statistics.

## Survey Size

From a universe of 23,105 nursing homes, 1,698 facilities were sampled; 166 were excluded for being out of the scope of the survey or out of business; 1,451 responded.

## Survey Design

The design consists of a stratified two-stage probability sample where the first stage involves a selection of facilities and the second stage involves a selection of residents, persons discharged in 1976, and employees.

For the first stage sampling, two different procedures are used: one for facilities listed in the NMFI with known bed size and another for newly opened facilities for which bed size and service type are unknown.

Interviewers carry out the second stage sampling of residents, discharges in 1976, and employees at the time of their visits to the facilities in accordance with specific instructions. Residents are sampled from the total number of residents on the register of the facility on the evening prior to the day of the survey. An average of five residents per facility are sampled. Discharges are selected from the total number of persons discharged alive or dead during calendar year 1976. An average of four discharges per facility are in the sample. Employees are sampled from the staff sampling list. An average of 10 staff per facility are in the sample.

## Data Source

Administrators or owners are interviewed for the facility questionnaire. Accountants or other knowledgeable staff members respond to the expense questionnaire, or the facilities' financial statements are reviewed by a survey accountant. Staff members closest to the individually sampled patient respond to the current resident questionnaire. Nursing staff complete the discharged resident questionnaire by referring to medical records. Sampled staff members respond to the staff questionnaire.

## Estimation (Case Weighting) Scheme

A ratio estimating procedure is used. The estimation of the number of facilities and facility data not related to size are inflated by the reciprocal of the probability of selecting the sample facilities and adjusted for the nonresponding facilities. In addition, a first stage ratio adjustment was applied to bring the sample in closer agreement with the known universe of beds. The estimation of resident, discharge and staff data are inflated by the preceding adjustments applied to facilities, as well as by the reciprocal of the probability of selection of the sample unit (resident, discharge or staff) and adjustments for the nonresponding sample units.

## Response Rates

Response rates are 95 percent for the facility questionnaire, 85 percent for the expense questionnaire, 99 percent for current resident questionnaires, 97 percent for discharged resident questionnaires, and 81 percent for the staff questionnaires.

## Treatment of Missing Values

Public use data tapes are edited to eliminate missing values. Blank responses are imputed to the most predominate value for that variable. For example, if the value for sex is missing, the response "female" is imputed because most residents are female. The "don't know" response is used if there is no precedent for the value.

## Sampling Error

For this survey, published estimates that have a relative standard error of more than 30 percent are considered "unreliable." Nineteen tables are available for standard errors for facilities, residents, discharges, employees, beds, admissions, etc. in the public use data tape, documentation and published reports. For a relative standard error of 30 percent or less, a minimum estimate of 3,500 residents is required; for discharges, the minimum estimate is 5,000.

## KEY VARIABLES AND VARIABLE BREAKDOWNS

### Age

Less than 45 years, 45-54, 55-64, 65-69, 70-74, 75-79, 80-84, 85-89, 90-94, 95 and over.

Data tape provides age in exact years for each resident.

### Race/Ethnicity

White (not of Hispanic origin), Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic, unknown.

### Family Income

Not reported.

### Employment Status

Not reported.

### Rural/Urban Residence

Not reported.

### Disabling Conditions/Functional Limitations

Selected Health Statuses:

Primary diagnoses at time of admission coded according to the diseases and disease group categories of the International Classification of Diseases (8th Revision). This includes codes for chronic conditions and impairments, such as mental retardation, paralysis or palsy, and chronic brain syndrome.

Primary diagnosis at last medical examination coded as above.

Primary reason for care coded as: poor physical health, mental illness, mental retardation, behavioral problem, social reason, economic or other reason.

Functional Status:

Degree of impairment in vision, hearing and speech, coded as: partially impaired, severely impaired, deaf or blind or cannot speak, unknown.

Reason for nonverbal communication coded as: does not speak English, cannot talk, too ill, mental or emotional problem, other, unknown.

Behavioral problem coded as: depressed or withdrawn; agitated or nervous; abusive, aggressive or disruptive; wandering; other.

Degree of dependency in activities of daily living (i.e., bathing, dressing, use of toilet room, mobility, continence, eating) coded as: requires/does not require assistance or the help of special equipment.

Index of dependency in activities of daily living coded as: number of activities in which resident is dependent.

Whether resident is chairbound or bedfast.

Use of special aids coded as: whether resident uses any of 16 different special aids such as wheelchair, mechanical feeding device, eyeglasses, etc.

### Family Composition

Persons living with resident prior to entering the facility and persons living with resident after discharge coded as: spouse, child, parent, brother or sister, other relative, unrelated person. Description of types of visitors from outside the facility, including family members, also coded.

## Beneficiary Status for Major Federal Programs

Primary source of payment for care during the charge period listed for residents including: Medicare, Medicaid—skilled nursing, Medicaid—intermediate care, other government assistance or welfare, Veterans Administration contract.

## Other Health Related Data

Reported.

## Other Demographic Data

Sex, marital status.

## Geographical Area

State:

Not reported.

Region:

Area of nursing homes is coded as: Northeast, North Central, South, West, and by Standard Federal Administrative Region, Regions I-X (a grouping of coterminous states into ten regions which is used throughout the Federal government).

SMSA:

Not reported.

## Service Utilization

### Types of Services

Physician visits plus 23 different types of medically related services (e.g., blood pressure reading, catheter sterilization, eight different types of therapy such as physical therapy, etc.).

## Level of Utilization

Reported for some services.

## AVAILABILITY OF DATA

Four tapes are available:

- 1) Facility—expense
- 2) Current resident
- 3) Discharged resident
- 4) Staff

## Price of Data or Tapes

All four tapes must be purchased as a set for \$460. Tape order number is PB 80188030.

## User Representative

Esther Hing  
Long Term Care Statistics Branch  
National Center for Health Statistics  
3700 East West Highway  
Hyattsville, MD 20782  
(301) 436-8830

Order Point:

National Technical Information Service  
5285 Port Royal Road  
Springfield, VA 22161  
(703) 487-4600

## TAPE CHARACTERISTICS

### Density

1600 bpi.  
6250 bpi is available as a special order.

## Number of Tracks

Nine.

## Magnetic Recording Codes

EBCDIC.

## Preformatted

No.

## Data Structure

Rectangular; however, hierarchical files can be created.

## Technical Documentation

*Public Use Data Tape Documentation: National Nursing Home Survey, 1977.* Hyattsville, MD: National Center for Health Statistics, October 1984.

# SURVEY EVALUATION

## Narrative Assessment

Contains detailed information on disabling conditions and on the nature and severity of related functional limitations.

## Prior Users and Use Reports

Bloom, B. Utilization and Financial Characteristics of Nursing Homes in the United States: 1977 National Nursing Home Survey. *Vital and Health Statistics*, 13 (53), August 1981.

Foley, D.J. Nursing Home Utilization in California, Illinois, Massachusetts, New York, and Texas, 1977 National Nursing Home Survey. *Vital and Health Statistics*, 13 (48), October 1980.

Hing, E. and Zappolo, A. A Comparison of Nursing Home Residents and Discharges from the 1977 National Nursing Home Survey, United States. *Advance Data from Vital and Health Statistics*, 29, May 17, 1978.

Hing, E. Characteristics of Nursing Home Residents, Health Status, and Care Received: 1977 National Nursing Home Survey. *Vital and Health Statistics*, 13 (51), April 1981.

Meiners, M. An Overview of Nursing Home Characteristics, Provisional Data from the 1977 National Nursing Home Survey. *Advance Data from Vital and Health Statistics*, 35, September 6, 1978.

Sirrocco, A. Employees in Nursing Homes in the United States, 1977 National Nursing Home Survey. *Vital and Health Statistics*, 14 (25), February 1981.

Van Nostrand, Joan, Zappolo, Aurora, Hing, Esther and Bloom, Barbara, et al. The National Nursing Home Survey, 1977 Summary of the United States. *Vital and Health Statistics*, 13 (43), July 1979.

Zappolo, A. Discharges from Nursing Homes, 1977 National Nursing Home Survey. *Vital and Health Statistics*, 13 (54), August 1981.



# NATIONAL SPINAL CORD INJURY STATISTICAL CENTER

## CONTACT

Dr. Phillip Fine  
National Spinal Cord Injury Statistical Center  
Spain Rehabilitation Center, Room 522  
University of Alabama at Birmingham  
University Station  
Birmingham, AL 35294  
(205) 934-3334

## SPONSOR

National Institute on Disability and Rehabilitation  
Research.

## PERIOD

1973-1985.

## SURVEY DESCRIPTION

### Survey Objectives

To collect and analyze data reported by the Model Spinal Cord Injury (SCI) Systems. These Demonstration Model Spinal Cord Injury Systems are strategically located throughout the United States and are sponsored by the National Institute on Disability and Rehabilitation Research. The Model SCI system concept emphasizes a coordinated system of care from point of injury through rehabilitation and life-time followup.

Each System is responsible for collecting data regarding clinical events following spinal cord injury. These data were collected and analyzed from 1973-1981 at the National Spinal Cord Injury Data Research Center in Phoenix, Arizona. This information was disseminated through the

quarterly *Model Systems Spinal Cord Injury Digest*. *Spinal Cord Injury Statistics* is a final report of statistics on spinal cord injury collected at the Research Center on 6,104 cases from 1973 through 1981.

Data collected at the National SCI Statistical Center from 1981 through 1985 are being analyzed at the University of Alabama in Birmingham. These data together with analyses based on the data collected by the Good Samaritan Medical Center have been published in *Spinal Cord Injury: The Facts and Figures* (see "Prior Users and Use Reports" below).

## Population Surveyed

Persons served in the Model SCI systems are research subjects. Each Model System project has an identified catchment area. The authors of *Spinal Cord Injury Statistics* estimate that the data bank sample represents approximately 10 percent of the annual United States incidence of Spinal Cord Injury for the years in which the Data Research Center was in operation (1975-1982). Persons treated in hospitals which are not included in the Model Spinal Cord Injury Systems are not reported in the system databank.

## Survey Size

9,897 total reported cases as of January 1986.

## Survey Design

The data bank includes data on all spinal cord injury hospitalizations reported in 13 Model Spinal Cord Injury Systems.

## Data Source

Data are collected by the Model Spinal Cord Injury staff at the individual System Centers. Data are drawn from medical records and interviews with patients.

### Estimation (Case Weighting) Scheme

Prevalence rates were calculated based on census data, derived mean life expectancy of spinal cord injury victims and previously estimated incidence rates.

### Response Rates

Rates have been calculated for the recent data but will not be published. Interested parties should contact Dr. Samuel Stover at the Spain Rehabilitation Center.

### Treatment of Missing Values

Individual items coded as unknown are not included in compilation of data.

### Sampling Error

Not applicable.

## KEY VARIABLES AND VARIABLE BREAKDOWNS

### Age

15 Years, 16-30, 31-45, 46-60, 61-75, 76-90, mean and median age at time of injury.

### Race/Ethnicity:

Caucasian, Black American, American Indian, Spanish origin, Asian, other unclassified, unknown.

### Family Income

Pre-injury income for people employed at time of injury: \$0-\$4,999; 5,000-9,999; 10,000-14,999; 15,000-19,999; 20,000-24,999; 25,000-29,999; 30,000-34,999; 35,000-39,999; 40,000-44,999; 45,000-49,999; 50,000 and over.

Percent of pre-injury income earned in followup years for individuals working at onset of injury.

### Employment Status

Reported.

### Rural/Urban Residence

Not reported.

### Disabling Conditions/Functional Limitations

Pre-existing medical conditions:

Twenty categories (e.g., diabetes, personality disorders, heart disease/ischemia, hydronephrosis, etc.).

Categories of neurological impairment:

Paraplegia, incomplete; paraplegia, complete; quadriplegia, incomplete; quadriplegia, complete; normal neurological, minimal neurological deficit; other, unclassified; unknown.

Independence in functional activities:

Eating and drinking, dressing, grooming, washing and bathing, bladder care, bowel care, transfer from chair to toilet, walk (50 yards), climbs stairs.

Hours of physical assistance required per day.

Age of onset (duration).

### Family Composition

Not reported.

### Beneficiary Status for Major Federal Programs

Rehabilitation services.

## Other Health Related Data

Reported.

## Other Demographic Data

Sex, marital status (at time of injury), education.

## Geographical Area

State:

Not reported.

Region:

(Geographical area of injury site): New England, Middle Atlantic, East North Central, West North Central, West South Central, Mountain, Pacific.

SMSA:

Not reported.

## Service Utilization

### Types of Services

Comprehensive medical rehabilitation, psychosocial services, operative procedures, urinary management, mechanical respiration, environmental modifications, attendant care, vocational rehabilitation, nursing home, hospitalization.

### Level of Utilization

Reported for some services.

## AVAILABILITY OF DATA

The sole proprietors of the data tapes are each of the contributing Model Systems. Data tapes are not available; only reports may be purchased.

## Price of Data or Tapes

\$49.95 plus \$2.95 handling charge

## User Representative

Dr. Phillip Fine  
National Spinal Cord Injury Statistical Center  
Spain Rehabilitation Center, Room 522  
University of Alabama at Birmingham  
University Station  
Birmingham, Alabama 35294  
(205) 934-3334

Contributing Model Systems may be contacted regarding their data. Requests for special analyses should be addressed to:

Dr. J. Paul Thomas, Director  
Medical Sciences Programs  
National Institute on Disability and Rehabilitation Research  
Mail Stop 2304  
Washington, DC 20202  
(202) 732-1194

## SURVEY EVALUATION

### Narrative Assessment

Data collected are representative of the clients served by the Model Spinal Cord Injury Systems. Any differences between these clients and the national SCI population are unknown.

### Prior Users and Use Reports

DeVivo, Michael, Fine, P. and Stover, S. The Prevalence of SCI, A Reestimation Based on Lifetables. *Spinal Cord Injury Digest*, Winter, 1980.

Gordon, Dorothy. *Consequences of Trauma Centers*. Paper presented at the American Academy of Physical Medicine and Rehabilitation Scientific Sessions, Kansas City, October 3, 1985. Information can be obtained from Dr. Gordon at the National Rehabilitation Hospital, Washington, DC, (202) 877-1000.

Stover, Samuel L. and Fine, Phillip R. (eds.). *Spinal Cord Injury: The Facts and Figures*. Birmingham: National Spinal Cord Injury Statistical Center, University of Alabama at Birmingham, 1986.

## NATIONAL SURVEY OF RESIDENTIAL FACILITIES

### CONTACT

Bradley Hill  
Center for Residential and Community Services  
207 Pattee Hall  
150 Pillsbury Drive, SE  
University of Minnesota  
Minneapolis, MN 55455  
(612) 624-7337

### SPONSOR

Health Care Financing Administration, U.S. Department  
of Health and Human Services.

### PERIOD

As of June 30, 1982.

### SURVEY DESCRIPTION

#### Survey Objectives

To examine national patterns of residential programs serving persons who are mentally retarded.

#### Population Surveyed

The census includes residents of facilities and homes that meet the following definition of a residential facility: Any living quarters which provided 24-hour, 7 days-a-week responsibility for room, board, and supervision of mentally retarded people with the exception of (a) single family homes providing services to a relative, (b) nursing homes and foster homes that are not formally state licensed or contracted as mental retardation service providers, and (c) independent living (apartment) programs

that have no staff residing in the home facility as of June 30, 1982.

Semi-independent living programs are included only if staff members are in the building at all times when residents are home. Apartment units with shared staff members in one building are viewed as one program facility and covered by a single questionnaire.

### **Survey Size**

Residential facilities serving 279,095 residents of whom 243,669 are mentally retarded.

### **Survey Design**

Data collection for traditional state-operated public residential facilities (institutions) is conducted under the auspices of the National Association of Superintendents of Public Residential Facilities for the Mentally Retarded. Data are obtained from questionnaires that were mailed to administrators of 278 public residential facilities during August 1982, and followed up in October with short-form questionnaires.

The survey of the remaining 20,859 facilities was directly conducted by the Center. These data are obtained from questionnaires initially mailed to 19,159 facilities/homes between September 3 and 8, 1982. There are two mail followups conducted in September and October 1982, succeeded in November through March by several special followups of selected group facilities. Telephone interviewing of all nonrespondents began in December 1982, and ended in June 1983.

### **Data Source**

Self-administered mail questionnaires with two mail followups and telephone followups.

### **Estimation (Case Weighting) Scheme**

Not applicable.

### **Response Rates**

94.5 percent or 14,769 of the 15,633 facilities responding.

### **Treatment of Missing Values**

Missing values for total residents and for mentally retarded residents were estimated by the states. Missing values for other variables are estimated from data for the same types and sizes of facilities within the same state.

### **Sampling Error**

Not applicable.

## **KEY VARIABLES AND VARIABLE BREAKDOWNS**

### **Age**

0-4 years, 5-9, 10-14, 15-21, 22-39, 40-62, 63 and over.

### **Race/Ethnicity**

Not reported.

### **Family Income**

Not reported.

### **Employment Status**

Not reported.

### **Rural/Urban Residence**

Not reported.

### **Disabling Conditions/Functional Limitations**

Indication of the number of mentally retarded residents by level of retardation on June 30, 1982: borderline (69-84), mild (52-68), moderate (36-51), severe (20-35), profound (below 20), unknown.

Indication of the number of mentally retarded residents who: cannot walk without assistance, cannot dress without assistance, cannot eat without assistance, cannot understand the spoken word, cannot communicate verbally, are not toilet trained.

### **Family Composition**

Not reported.

### **Beneficiary Status for Major Federal Programs**

The number of participants in the Medicaid/ICFMR program is reported.

### **Other Health Related Data**

Not reported.

### **Other Demographic Data**

Sex.

### **Geographical Area**

State:

Reported.

Region:

Not reported.

SMSA:

Not reported.

### **Service Utilization**

Not reported.

### **AVAILABILITY OF DATA**

Tapes will be available in the near future.

### **Price of Data or Tapes**

\$1000 per tape.

\$10 codebook.

### **User Representative**

Bradley Hill  
Center for Residential and Community Services  
207 Pattee Hall  
150 Pillsbury Drive, SE  
University of Minnesota  
Minneapolis, MN 55455  
(612) 624-7337

### **TAPE CHARACTERISTICS**

#### **Density**

1600 bpi.

#### **Number of Tracks**

Nine.

#### **Magnetic Recording Codes**

ASCII or EBCDIC.

#### **Preformatted**

SPSS.



## Data Structure

These are SPSS files that may be written into rectangular files.

## Technical Documentation

Hauber, F.A., Bruininks, R.H., Hill, B.K., Lakin, K.C., et al. *National Census of Residential Facilities: Fiscal Year 1982*. Minneapolis: University of Minnesota, Department of Educational Psychology, 1982.

## SURVEY EVALUATION

### Narrative Assessment

There are analytical limitations in that resident data are gathered in aggregate form (by facility) and thus resident characteristics cannot be cross-tabulated.

### Prior Users and Use Reports

Hauber, F.A., Bruininks, R.H., Hill, B.K., Lakin, K.C., et al. *National Census of Residential Facilities: Fiscal Year 1982*. Minneapolis: University of Minnesota, Department of Educational Psychology, 1984.

Hill, B.K., Bruininks, R.H., Lakin, K.C., Hauber, F.A. et al. *Stability of Residential Facilities For Mentally Retarded People: 1977-1982*. Minneapolis: Center for Residential and Community Services, Department of Educational Psychology, University of Minnesota, 1984.

Hill, B.K. and Lakin, K.C. *Classification of Residential Facilities for Mentally Retarded People*. Minneapolis: Center for Residential and Community Services, Department of Educational Psychology, University of Minnesota, 1984.

## NATIONAL SURVEY OF STROKE

## CONTACT

Morton Robins  
Westat Research  
1650 Research Boulevard  
Rockville, MD 20850  
(301) 251-8270

## SPONSOR

National Institute of Neurological and Communicative Disorders and Stroke (NINCDS).

## PERIOD

1971, 1973, 1975, 1976.

## SURVEY DESCRIPTION

### Survey Objectives

This is one of several surveys designed to meet the National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) needs for health statistics. The chief goal of these surveys is to obtain precise national estimates of the incidence, prevalence, and economic costs of selected disorders. These estimates are needed to set priorities, to help allocate health resources, and to assist in regulatory and planning efforts.

### Population Surveyed

Civilian stroke patients discharged from short-term general hospitals in the contiguous United States.

### Survey Size

The sample consists of 124 hospitals drawn from the 6,140 short-term general hospitals in the contiguous United

States in 1974. Of 2,710 patient records reviewed and abstracted, 1,846 are included in the study. About 400 patients or next of kin provide questionnaire data on cost and impact of illness.

### Survey Design

The probability sampling plan consists of three stages. In the first stage, short-term stay general hospitals are identified in the 1974 Master Facility Inventory (MFI) of the National Center for Health Statistics. The MFI is a census of all inpatient health facilities conducted every two to three years. These hospitals are stratified by size within Standard Metropolitan Statistical Areas (SMSA's) or non-SMSA territories and by four geographic regions of the country.

In the second stage, hospitals are divided into two groups by size. Each group is divided into zones estimated to have an equal number of stroke discharges. Each zone is further divided into clusters with approximately three hospitals per cluster. Selecting one sample cluster per zone yields 124 selected hospitals.

In the third stage, sampling is based on a record review of all patients from cooperating hospitals who have a discharge diagnosis of stroke for the years 1971, 1973, 1975, and 1976. Selecting a stratified, systematic random sample of 2,710 records, and excluding 864 (31.9 percent) of these for not meeting the specifications of acute stroke, yields a final sample size of 1,846 records.

In addition, from the 1,846 records, 687 are identified for a followup questionnaire on the impact and costs of illness. Those not designated for this followup are persons who had died prior to January 1, 1976. Followup interviews for 180 persons who died after January 1, 1976 are conducted with the next of kin.

The sample size for this component is further reduced because of a requirement that permission be obtained from the hospital and/or the physician to contact a sur-

living patient. Questionnaires from approximately 289 surviving patients and 107 next of kin (or a total of 396) comprise the data set for the economic impact study.

### Data Source

Hospital records selected for the study are abstracted by trained survey staff and then reviewed by a trained nosologist (i.e., person who specializes in classifications or taxonomies), to determine if the patient is within the study definition of acute stroke.

The impact and costs of illness questionnaire is completed either by mail or by a personal interview with the patient or with the next of kin of deceased or incapacitated patients.

### Estimation (Case Weighting) Scheme

The estimation methodology for prevalence involves three steps: (1) estimating the magnitude of new cases for each series of cohorts, beginning with the time period of 1918-1922 and ending with the 30-day period just prior to the prevalence date, (2) estimating the number of survivors of these cohorts as of the prevalence date, and (3) aggregating the various cohort estimates and then reclassifying the survivors into broad age groups based on their ages as of the prevalence date.

Application of this methodology requires the following underlying assumptions: 1) age-specific incidence rates of initial strokes in the U.S. have remained constant over the past 50 years and can be estimated from the incidence data generated by this survey for the period 1975-1976, 2) "short-term" age-specific survival rates after a patient's initial stroke, in the U.S., have also remained constant over the past 50 years and can be estimated from the survival data presented in the previous section, and 3) survival of stroke patients for a specified "extended" number of years means they can be considered to have the same mortality risk as the general population. Appropriate U.S. life tables can then be applied to such "long-term" stroke survivors to estimate their subsequent survivorship.

## Response Rates

The response rate for hospitals allowing records to be abstracted is approximately 80 percent; for hospitals participating in the latter phases of the survey (i.e., permitting followup interviews with patient or close relative), 65.5 percent; and for patients completing questionnaires, 57.6 percent. Failure to locate discharged patients or next of kin, physician or hospital contraindications, or failure to respond, account for nonresponse on followup cases.

## Treatment of Missing Values

Missing items for which tabulations are carried out (e.g., death, clinical signs and symptoms) are imputed using a "hot deck" technique. Patient records or questionnaires are stratified by key characteristics. Cards are shuffled randomly and missing items are given the same values of the variable of the next card. Items which are not tabulated (e.g., specific individual lab results) are left as unknown in the data set.

## Sampling Error

The coefficients of variation (CV) for estimates of the number of initial and total attacks of stroke in the hospital are calculated for various categories of estimated number of attacks. The CV's for an estimated 100,000 initial and total attacks are 11.8 and 12.2 percent respectively.

## KEY VARIABLES AND VARIABLE BREAKDOWNS

### Age

Less than 35 years, 35-44, 45-54, 55-64, 65-74, 75-84, 85 and over.

### Race/Ethnicity

Not reported.

### Family Income

Not reported.

### Employment Status

Not reported.

### Rural/Urban Residence

Not reported.

### Disabling Conditions/Functional Limitations

Symptoms and signs associated with stroke including: seizures, paralyses, speech difficulties.

### Family Composition

Not reported.

### Beneficiary Status for Major Federal Programs

Medicare, Medicaid, Veterans Administration.

### Other Health Related Data

Reported.

### Other Demographic Data

Sex, marital status.

### Geographical Area

State:

Not reported.

Region:

Physician cost data are available by region: East, North Central, South, and West.

SMSA:

Not reported.

Dallas, TX 75231  
(214) 278-1346

## SURVEY EVALUATION

### Service Utilization

#### Types of Services

Physical therapy, speech therapy, occupational therapy, vocational rehabilitation services, social work services, public health nursing services, private duty nursing services, special diagnostic procedures, surgical procedures, medicinal therapy.

#### Level of Utilization

Reported.

### AVAILABILITY OF DATA

A summary report and the full report are available as listed below.

#### Price of Data or Tapes

A summarized report is available free of charge.

#### User Representative

National Institute of Neurological and Communicative Disorders and Stroke  
National Institutes of Health  
Bethesda, MD 20205  
(301) 498-5751  
Publication No. NIH 83-2069

The complete report may be obtained for \$7.20 by requesting Monograph #75, Item #73061A from:

Distribution Department  
National Center for the American Heart Association  
7320 Greenville Avenue

### Narrative Assessment

Provides national baseline data on the prevalence and associated costs of stroke. Although the response rate is low, particularly on the economic cost and impact of illness questionnaire, the estimates compare well with other statistics. Estimates are made despite the response rate because the authors feel that there is little or no bias due to nonresponse. Much nonresponse had to do with physician unwillingness to permit followup.

There is relatively little data on disabling conditions or functional limitations. Race data are collected but not reported as the authors feel the estimates are unreliable.

### Prior Users and Use Reports

*National Survey of Stroke*. Washington: National Institute of Neurological and Communicative Disorders and Stroke, Office of Biometry and Field Studies, reprint June 1983.

Weinfeld, Fred (ed.). *The National Survey of Stroke. Stroke, 12, Supplement 1*, March/April 1981.

# NATIONAL SURVEY OF TRANSPORTATION HANDICAPPED PEOPLE

## CONTACT

Patricia Cass  
U.S. Department of Transportation  
Urban Mass Transportation Administration  
400 7th Street, SW  
Washington, DC 20590  
(202) 426-4484

## SPONSOR

Urban Mass Transportation Administration, U.S.  
Department of Transportation.

## PERIOD

May 1976 - January 1977.

## SURVEY DESCRIPTION

### Survey Objectives

This survey is a part of a major effort undertaken by the Urban Mass Transportation Administration (UMTA) of the U.S. Department of Transportation (DOT) in response to Congressional interest in and legislation for the planning and design of mass transportation facilities to meet special needs of elderly and handicapped persons.

### Population Surveyed

The national urban population with three identified subgroups: (1) transportation handicapped individuals living in urban areas, (2) transportation handicapped individuals living in institutions, and (3) nontransportation handicapped individuals.

## Survey Size

15,704 households and 42,349 persons screened; 1,500 persons with transportation handicaps and living in households interviewed; 597 persons without transportation handicaps and living in households interviewed; 295 persons with transportation handicaps and living in institutions interviewed.

## Survey Design

A national probability sample of 50,000 households in urban areas. Of these, 2,192 people were identified as transportation handicapped.

Transportation handicapped individuals are defined as persons who have experienced general problems in the past 12 months such as visual, hearing, use of mechanical aids or wheelchair, or other problems and who perceive themselves as having greater difficulty using public transportation than persons without their general problems, and who are not housebound.

The survey includes 1,500 followup interviews with those identified as transportation handicapped and 597 full interviews with persons in the original household screening identified as not transportation handicapped.

In addition, 295 full interviews with respondents living in institutions who qualify as transportation handicapped are included. This sample is drawn from 100 geographically dispersed institutions located in mass transit areas. No more than three interviews per institution are included in the survey.

## Data Source

Personal home interviews.

## Estimation (Case Weighting) Scheme

The household screening sample cases are weighted: (1) to adjust for over/under sampling in mass/non-mass transit



areas, and (2) to adjust for over/under sampling after adjusting for mass/non-mass sample sizes. Cases in the final interviews of the sample are weighted: (1) to match weighted screenings for mass/non-mass transit areas, (2) to match screenings for specific physical problems (blindness, wheelchairs), and (3) to match screenings on riders/non-riders among the non-transportation handicapped people.

No national data are available as a basis for weighting the institutional sample cases.

#### **Response Rates**

Not reported.

#### **Treatment of Missing Values**

Not reported.

#### **Sampling Error**

Not reported.

### **KEY VARIABLES AND VARIABLE BREAKDOWNS**

#### **Age**

Less than 15 years, 15-24, 25-39, 40-54, 55-64, 65 and over.

#### **Race/Ethnicity**

Black, white, other.

#### **Famly Income**

Less than \$4,000; 4,000-5,999; 6,000-7,999; 8,000-9,999; 10,000-14,999; 15,000-24,999; 25,000 and over.

#### **Employment Status**

Reported.

#### **Rural/Urban Residence**

Only urban areas sampled.

#### **Disabling Conditions/Functional Limitations**

Difficulty: going up and down stairs/inclines, stooping/kneeling/crouching, waiting/standing, walking more than one block, lifting/carrying, sitting/getting up, moving in crowds, reaching/handling/grasping.

Specific Dysfunction: uses mechanical aids, has a hearing dysfunction, has a visual dysfunction, uses a wheelchair.

#### **Family Composition**

Number of persons in household: 1, 2, 3, 4, 5 and over.

#### **Beneficiary Status for Major Federal Programs**

Social Security, Supplemental Security Income, public assistance, welfare, Veterans benefits, food stamps, railroad retirement, other federal.

#### **Other Health Related Data**

Not reported.

#### **Other Demographic Data**

Sex, education.

#### **Geographical Area**

State:

Not reported.

Region:

Northeast, Southeast, North Central, South Central, Mountain, Pacific.



SMSA:

Not reported.

### Service Utilization

#### Types of Services

In-home social services such as "meals on wheels" or visiting nurses.

#### Level of Utilization

Not reported.

### AVAILABILITY OF DATA

Printed report may be obtained; however, no tapes are available.

#### Price of Data or Tapes

Each report is \$25 plus a \$3 handling charge.

#### User Representative

Order Point:

National Technical Information Service  
5285 Port Royal Road  
Springfield, VA 22161  
(703) 487-4600

### SURVEY EVALUATION

#### Narrative Assessment

The survey provides detailed data on persons who are transportation handicapped in urban areas. Mentally disabled persons are not identified as transportation handicapped.

### Prior Users and Use Reports

*Urban Transportation for Handicapped Persons. Alternative Federal Approaches.* Washington: Congressional Budget Office, November 1979.

*Technical Report of the National Survey of Transportation Handicapped People.* Washington: Department of Transportation, Urban Mass Transportation Administration, September 1978.

# PERSONS IN INSTITUTIONS AND OTHER GROUP QUARTERS (1980)

## CONTACT

Carolyn Rogers  
Bureau of the Census  
U.S. Department of Commerce  
Washington, DC 20233  
(301) 763-7883

## SPONSOR

Bureau of the Census.

## PERIOD

Decennial. The following information is based on the 1980 Census.

## SURVEY DESCRIPTION

### Survey Objectives

To provide a census of the characteristics of the population under care or custody in institutions and other group quarters.

### Population Surveyed

Persons living in institutions—correctional facilities, mental (psychiatric) hospitals, residential treatment centers, tuberculosis hospitals, other chronic disease hospitals, homes for the aged, homes and schools for the mentally handicapped [public and private], homes and schools for the physically handicapped, homes for dependent and neglected children, homes for unwed mothers, training schools for juvenile delinquents [public and private], and detention homes.

Persons living in other (noninstitutional) group quarters—rooming houses (houses with nine residents or more not related to the householder), temporary motels, hotels, Y's charging four dollars or more, military barracks, college dormitories, communes, halfway houses, religious group quarters, workers dorms, low cost transient quarters, commercial ships, general hospital or nurses dormitories, institutional staff quarters.

## Survey Size

An estimated 2,492,157 persons are inmates or patients in institutions, and an estimated 3,246,266 persons live in other group quarters.

## Survey Design

The basic sampling unit for the 1980 Census was the housing unit, including all occupants. For persons living in group quarters, however, the sampling unit was the person.

Two sampling rates were employed. In counties, incorporated places, and minor civil divisions estimated to have fewer than 2,500 persons (based on pre-census estimates), one-half of all persons in group quarters were included in the sample. In all other areas one-sixth of the persons in group quarters were sampled.

## Data Source

Individual Census Reports (ICR's) were used for the enumeration of persons in group quarters. These forms contained population questions, but did not include any housing questions. Facilities were not enumerated by mail because there was no way of knowing in advance how many people are residing at these places at a given time making it impossible for the Bureau of the Census to ascertain the number of questionnaires to send or to be received from them. Enumerators visited each facility and conducted the enumeration by interviewing occupants directly, by leaving ICR's, or by transcribing information from institution records.

## Estimation (Case Weighting) Scheme

Estimates are obtained from an iterative ratio estimation procedure which results in the assignment of a weight to each sample person or housing unit record. This weight is approximately equal to the inverse of the probability of selecting a person for the census sample.

These initial weights are ratio-adjusted within census tabulation areas to complete census counts by 17 household-type groups including persons in group quarters, householder and non-householder status, and by 160 possible sex-race-Spanish origin groups.

The estimates produced by this procedure realize some of the gains in sampling efficiency that would have resulted if the population had been stratified into the ratio estimation groups before sampling and the sampling rate had been applied independently to each group. The net effect is a reduction in both the standard error and the possible bias of most estimated characteristics to levels below what would have resulted by simply using the initial (unadjusted) weights.

## Response Rates

Response rate information is not available separately for the long versus short form questionnaire. Due to extensive follow up and allocation procedures, only 1.2 percent of households and persons in institutions and other group quarters failed to respond at all to the 1980 Census. For these cases, the entire questionnaire is imputed. In the remaining 98.8 percent of the cases at least some information is obtained, providing a basis for allocating values to any missing items (see "Treatment of Missing Values" below).

## Treatment of Missing Values

Unreturned questionnaires are followed up extensively by Census enumerators. Data are adjusted for nonresponses by allocating acceptable entries to replace blanks or unacceptable entries. The allocation procedure is based on using

information reported for another person with characteristics similar to those of the person for whom allocation is necessary.

## Sampling Error

Item	Estimate	Approximate Standard Error (based on 1 in 6 random sample)
No. of Persons Age 18 and Over in Homes and Schools for the Mentally Handicapped	118,967	753
No. of Persons Age 18 and Over in Homes and Schools for the Mentally Handicapped	16,596	287
No. of Persons Age 18 and Over in Men- tal (Psychiatric) Facilities and in Residential Treat- ment Centers	229,849	1,021

## KEY VARIABLES AND VARIABLE BREAKDOWNS\*

### Age

Age is broken down into a variety of categories depending upon the table. Generally, age in years is reported up to 21, after which four-year increments are reported up to 85 and over.

\*Reported as available in the Census publication *Persons in Institutions and Other Group Quarters* (1984), which draws from Census data tapes.

**Race/Ethnicity**

White, Black, Spanish origin (any race), not Spanish origin.

**Family Income**

Without income; \$1 - 1,999; 2,000 - 3,999; 4,000 - 5,999; 6,000 - 7,999; 8,000 - 9,999; 10,000 - 14,999; 15,000 - 24,999; 25,000 and over.

**Rural/Urban Residence**

Inside SMSA's (urban [central cities, not in central city], rural); outside SMSA's (urban, rural).

**Disabling Conditions/Functional Limitations**

It is assumed that persons residing in group quarters designed for handicapped persons specifically (i.e., psychiatric hospitals and residential treatment centers, tuberculosis hospitals and other chronic disease hospitals, homes and schools for the mentally and physically handicapped) are in fact disabled. In addition, for each respondent age 16 to 64 the following item is asked:

Does this person have a physical, mental or other health condition which has lasted for six or more months and which:

- (1) limits the kind or amount of work this person can do?
- (2) Prevents this person from working at a job?
- (3) Limits or prevents this person from using public transportation?

It should be noted that these items have a high nonresponse rate for persons in institutions.

**Family Composition**

Not reported.

**Beneficiary Status for Major Federal Programs**

Social Security, public assistance.

**Other Health Related Data**

Not reported.

**Geographical Area**

State:

Reported.

Region:

Northeast (New England, Middle Atlantic), North Central (East North Central, West North Central), South (South Atlantic, East South Central, West South Central), West (Mountain, Pacific).

SMSA:

Reported.

**Service Utilization**

Not reported.

**AVAILABILITY OF DATA**

Public use microdata sample and summary tape files are available; however, they do not provide the level of detail available from the Census Bureau internal file, used for Census publications. A full report entitled *Persons in Institutions and Other Group Quarters* (PC80-2-4D) may be purchased.

**User Representative**

Order Point:

Superintendent of Documents  
U.S. Government Printing Office

Washington, DC 20402  
(202) 783-3238  
Stock No. 003-024-06071-0

QUARTERLY CUMULATIVE CASELOAD  
REPORT (FORM RSA-113):  
STATE-FEDERAL PROGRAM OF  
VOCATIONAL REHABILITATION

**SURVEY EVALUATION**

**Narrative Assessment**

These data are a reliable source of information on the numbers and characteristics of presumably disabled persons living in institutions and other group quarters. The major limitations of the data are the absence of information on specific conditions, functional limitations, severity and duration of disability.

**Prior Users and Use Reports**

*Persons in Institutions and Other Group Quarters: 1980 Census of Population* (PC80-2-4D). Bureau of the Census, October 1984.

**CONTACT**

Larry Mars  
Rehabilitation Services Administration  
330 C Street, SW  
Room 3033A  
Washington, D.C. 20202  
(202) 732-1404

**SPONSOR**

Rehabilitation Services Administration  
Office of Special Education and Rehabilitative  
Services  
U.S. Department of Education

**PERIOD**

Quarterly caseload reports from state rehabilitation agencies are compiled yearly. National data on persons rehabilitated go back to Fiscal Year 1921 and on persons served, to Fiscal Year 1938.

**SURVEY DESCRIPTION**

**Survey Objectives**

Caseload statistics are collected quarterly on Form RSA-113 to show the flow of cases into and out of state rehabilitation agencies. The data are used to determine trends in the acceptance and rehabilitation of applicants for rehabilitation services and to permit the generation of various outcome measures that are used to assess state agency productivity. The data are also used in the budget development process.

### **Population Surveyed**

All cases of applicants for services and clients in receipt of services from state rehabilitation agencies are tabulated from the RSA-113 report.

### **Survey Size**

The total number of applicants and clients in state agency caseloads in Fiscal Year 1985 was 1,440,239, the fourth consecutive year in which the total exceeded 1.4 million.

### **Survey Design**

Information is reported quarterly in aggregate form on all persons who received or applied for services from state rehabilitation agencies through the quarter in question. Form RSA-113 has sections calling for the intake, outgo and caseload levels of (a) applicants, (b) persons in receipt of extended evaluation, and (c) active cases. A separate section on projections of future caseloads appears as well.

### **Data Source**

Form RSA-113 is received from each of 83 state rehabilitation agencies located in the 50 states, the District of Columbia, and all outlying territories. Some states have separate agencies for the blind and visually impaired.

### **Estimation (Case Weighting) Scheme**

Not applicable.

### **Response Rates**

A one hundred percent response rate is attained every year. Reporting is on a voluntary basis; however, state agencies are interested and cooperative.

### **Treatment of Missing Values**

All values are checked and totals are balanced so that no item is left missing. Any missing item or incorrect total is rechecked and completed by contacting the appropriate RSA regional office responsible for monitoring the program in the agency with questionable data. If necessary, the agency is contacted directly by the RSA central office.

### **Sampling Error**

Not applicable.

## **KEY VARIABLES AND VARIABLE BREAKDOWNS**

### **Age**

Not reported.

### **Race/Ethnicity**

Not reported.

### **Family Income**

Not reported.

### **Employment Status**

This is reported only in the form of whether or not the client was successfully rehabilitated.

### **Rural/Urban Residence**

Not reported.

### **Disabling Conditions/Functional Limitations**

Caseload data are requested for all clients in the active statuses and for those who are severely disabled. No data by disability type are available.



## Family Composition

Not reported.

## Beneficiary Status for Major Federal Programs

Among other elements, Form RSA-113 calls for the number of applicants determined eligible to receive vocational rehabilitation services.

## Other Health Related Data

Not reported.

## Other Demographic Data

Not reported.

## Geographical Area

State:

Caseload data cover all states, the District of Columbia, and outlying territories.

Region:

The State-Federal program is administered through ten RSA regional offices. Caseload data are tabulated for these ten regional offices as well as nationally and by individual agency.

SMSA:

Not reported.

## Service Utilization

### Types of Services

Not reported.

## Level of Utilization

Not reported.

## AVAILABILITY OF DATA

Tapes are not available. A report of findings can be ordered from the Rehabilitation Services Administration (see below).

## Price of Data or Tapes

No charge for report.

## User Representative

Larry Mars  
Rehabilitation Services Administration  
330 C Street, SW  
Room 3033A  
Washington, D.C. 20202  
(202) 732-1404

## Technical Documentation

See "Prior Users and Use Reports" below.

## SURVEY EVALUATION

### Narrative Assessment

These aggregated data do not contain demographic information, but they do serve to identify trends in numbers of applicants, persons served and persons rehabilitated in a very timely fashion. Caseloads of persons who are severely disabled are distinguished. A variety of measurements are developed to provide insights into program productivity and efficiency. Qualitative measurements are not available.

## Prior Users and Use Reports

The report, *Caseload Statistics*, is published annually. The last report in the series has the following citation:

*Caseload Statistics: State Vocational Rehabilitation Agencies, Fiscal Year 1984.* (RSA-IM-85-17). Rehabilitation Services Administration, March 1985.

## SAMPLE SURVEY OF ADMISSIONS TO STATE AND COUNTY MENTAL HOSPITALS

### CONTACT

Ronald W. Mandersheid, Ph.D.  
Chief  
Survey and Reports Branch  
Division of Biometry and Applied Sciences  
NIMH  
Room 18-C-07  
5600 Fishers Lane  
Rockville, MD 20857  
(301) 443-3343

### SPONSOR

National Institute of Mental Health (NIMH).

### PERIOD

1980.

### SURVEY DESCRIPTION

#### Survey Objectives

To obtain a profile of admissions to state and county mental hospitals.

#### Population Surveyed

Cohort of admissions to state and county mental hospitals drawn from hospitals reported in the 1979 NIMH Inventory of Mental Health Facilities.

#### Survey Size

4,867 admissions, or 1.4 percent of approximately 360,000 admissions reported annually in 156 of the 274 known state and county mental hospitals in the U.S.

## Survey Design

Two-stage stratified sample. In the first stage, the hospitals were stratified into four size strata. In the second stage, a probability sample of admissions was selected with the large hospital stratum having 25 percent of admissions selected and the small hospital stratum having 100 percent selected. Admissions to hospitals in the two middle strata were selected at rates between 25 percent and 100 percent. Additionally, in those states having large Native American populations, 100 percent of all admissions to sample hospitals were selected.

## Data Source

A mail survey was completed by hospital staff based on information in patient medical records. Data were collected at the time of admission and as of three months following admission.

## Estimation (Case Weighting) Scheme

The cases are weighted by the inverse of the probability of selection with an adjustment made for facility, patient, and item non-participation.

## Response Rates

156 or 92.3 percent of the 169 hospitals selected for the sample responded. Data were obtained for 100 percent of the patients selected for the sample.

## Treatment of Missing Values

Data for unanswered survey questions were allocated by copying data from the last case processed with similar characteristics ("hot deck" method).

## Sampling Error

Fifteen percent or less on a ten percent characteristic.

## KEY VARIABLES AND VARIABLE BREAKDOWNS

### Age

Age in years up to 99.

### Race/Ethnicity

Race: White, Black, Asian or Pacific Islander, American Indian or Alaskan Native, other.

Hispanic Origin: Hispanic, not Hispanic, unknown.

### Family Income

Not reported.

### Employment Status

Not reported.

### Rural/Urban Residence

Not reported.

### Disabling Conditions/Functional Limitations

Psychiatric diagnosis (Diagnostic and Statistical Manual or the International Classification of Diseases).

### Family Composition

Not reported.

### Beneficiary Status for Major Federal Programs

Medicare, Medicaid and others may be specified.

### Other Health Related Data

Not reported.

## Other Demographic Data

Sex, marital status, education.

## Geographical Area

Not reported.

## Service Utilization

### Types of Services

Individual therapy, family/couple therapy, group therapy, drug therapy, electro-convulsive therapy, detoxification, psychosurgery, self care skill training, social skill training, activity therapies, vocational training and rehabilitation, education, no psychiatric treatment rendered, other.

### Level of Utilization

Not reported.

## AVAILABILITY OF DATA

Data tapes are available.

### Price of Tapes

Available free of charge; however, a blank tape must be provided.

### User Representative

Ronald W. Manderscheid, Ph.D.  
Chief  
Survey and Reports Branch, DBAS, NIMH  
Room 18-C-07  
5600 Fishers Lane  
Rockville, MD 20857  
(301) 443-3343

## TAPE CHARACTERISTICS

### Density

6250 bpi.

### Number of Tracks

Nine

### Magnetic Recording Codes

EBCDIC.

### Preformatted

SAS.

### Data Structure

Rectangular.

### Technical Documentation

Available on request.

## SURVEY EVALUATION

### Narrative Assessment

Includes only those persons admitted to state and county mental hospitals.

It must be assumed that the person's admission to or residence in a state or county mental hospital indicates that his or her mental illness is disabling.

### Prior Users and Use Reports

Taube, Carl and Barrett, S. (eds.). *Mental Health, United States 1985*. Rockville, MD: National Institute of Mental Health, 1985.

# SECOND NATIONAL HEALTH AND NUTRITION EXAMINATION SURVEY (NHANESII)

## CONTACTS

Dale C. Hitchcock  
Survey Statistician  
Survey Planning and Development Branch  
Division of Health Examination Statistics  
National Center for Health Statistics  
3700 East-West Highway, Room 2-58  
Hyattsville, MD 20782  
(301) 436-7080

## SPONSOR

National Center for Health Statistics, U.S. Department of  
Health and Human Services.

## PERIOD

February 1976 - February 1980.

## SURVEY DESCRIPTION

### Survey Objectives

To provide estimates of prevalence of those health characteristics best identified through standardized medical examinations including tests and measurements used in clinical practice.

### Population Surveyed

Civilian noninstitutionalized population ages 6 months through 74 years.

## Survey Size

Sample size: 27,801.

		Children 6 months - 11 years	Adults 12-74 years
Number Interviewed	25,286	6,839	18,447
Number Examined	20,322	5,843	14,479

## Survey Design

The survey is based on a stratified, multi-stage, cross-sectional design that provides for the selection of samples at each stage with a known probability. In hierarchical order, the stages of selection are: primary sampling units (PSU's—a PSU is a county or a small group of contiguous counties); census enumeration districts (ED's); segments (a segment is a cluster of households); eligible persons; and finally, sample persons.

To oversample persons with low incomes, the ED's within each PSU are stratified into a poverty stratum and a non-poverty stratum. The sample of persons to be examined is selected so that the younger and older age groups are oversampled and so that approximately one person per sample household is selected. The sampling rates by ages are as follows:

Age	Rate
6 months - 5 years	3/4
6-59 years	1/4
60-74 years	3/4

## Data Source

Questionnaires on medical history, food consumption and health related behavior. Direct medical examination, tests, measurements, and laboratory procedures.

## Estimation (Case Weighting) Scheme

The estimation procedure has three basic components: (1) inflation by the reciprocal of the probability of selection, (2) adjustment for nonresponse, and (3) poststratification by age, sex, and race. A brief description of each component follows.

The probability of selection is the product of the probabilities of selection from each stage of selection in the design: PSU, segment, and sample person.

Then estimates are inflated by a multiplication factor that brings estimates based on examined persons up to a level that would have been achieved if all sample persons had been examined. The nonresponse adjustment factor is calculated by dividing the sum of the reciprocals of the probability of selection for all selected sample persons within each of five income groups (under \$6,000; \$6,000-9,999; \$10,000-14,999; \$15,000-\$24,999; and \$25,000 and over), three age groups (6 months - 5 years, 6-59 years, and 60-74 years), four geographic regions, and within or outside SMSA's by the sum of the reciprocals of the probability of selection for examined sample persons in the same income, age, region, and SMSA groups.

Finally, the estimates are ratio adjusted within each of 76 age-sex-race cells to independent estimates, provided by the U.S. Bureau of the Census.

## Response Rates

<u>Age</u>	<u>Interviews</u>		<u>Examinations</u>	
6 months-11 years	6,839	95.6%	5,843	81.7%
12 - 74 years	18,447	89.3%	14,479	70.1%
All	25,286	90.0%	20,322	73.1%

## Treatment of Missing Values

Shown as "blank but applicable" or just "blank" (meaning the question was not applicable to the respondent).

## Sampling Error

Estimates pertaining to disability could not be obtained.

## KEY VARIABLES AND VARIABLE BREAKDOWNS

### Age

6 months, 1, 2 . . . 74 years.

### Race/Ethnicity

Race: White, Black, other.

National origin or ancestry: countries of Central or South America, Chicano, Cuban, Mexican, Mexicano, or Mexican-American, Puerto Rican, other Spanish, other European (such as German, French, English, Irish), American Indian or Alaskan Native, Asian or Pacific Islander (such as Chinese, Japanese, Korean, Filipino, Samoan).

### Family Income

Under \$1,000; 1,000-1,999; 2,000-2,999; 3,000-3,999; 4,000-4,999; 5,000-5,999; 6,000-6,999; 7,000-9,999; 10,000-14,999; 15,000-19,999; 20,000-24,999; 25,000 and over.

### Employment Status

Reported.

### Rural/Urban Residence

Urban, rural (broken into seven size categories, e.g., urbanized area with 300,000 or more).



## **Disabling Conditions/Functional Limitations**

Persons ages 12-74 are asked:

### **Visual Impairment:**

Do you have any reason to think that you are color blind?

Have you ever had a test to see whether you are color blind?

Do you have serious trouble seeing with one or both eyes even when wearing glasses?

Can you see well enough to read ordinary newspaper print with glasses with your left eye? right eye?

### **Hearing Impairment:**

Have you ever had deafness or trouble hearing with one or both ears? Do not include any problems which lasted just a short period of time such as during a cold.

How old were you when you first began having trouble hearing?

Since the trouble began, has it gotten worse, better, or the same?

How would you rate your hearing in your right ear? Good, fair, poor, or are you deaf?

### **Functional Impairment:**

Do you have a physical disability or handicap which prevents or limits normal daily activities, such as the kind or amount of work that you can do, housework, schoolwork, using public transportation and so on?

What is the physical disability or handicap? (not coded on the data tapes).

How long have you had this disability or handicap?

Does this disability or handicap prevent you from . . .

working at a job or business? using any public transportation such as buses, trains and so on? taking care of any of your personal needs such as dressing or eating? doing work around the house?

Does (this disability or handicap) limit you in any of the above?

The questionnaire items given above serve as a supplement to findings from detailed clinical examinations and medical tests. For example, data from hematological and biochemical tests were collected.

## **Family Composition**

Relationship to head of household: head, one person living alone; head, two or more related persons in family; wife; child; other relative; foster child; husband.

## **Beneficiary Status for Major Federal Programs**

Social Security, public assistance, unemployment compensation or workers' compensation, Veterans benefits, and food stamps.

## **Other Health Related Data**

Reported.

## **Other Demographic Data**

Sex, education.

## **Geographical Area**

State:

Not reported.

Region:

Northeast, South, Midwest, West.

SMSA:

SMSA, not SMSA.

#### Service Utilization

##### Types of Services

Doctors, hospitals.

##### Level of Utilization

Reported.

#### AVAILABILITY OF DATA

##### Price of Data or Tapes

Medical History Reel

Adults (12-74 years)

Accession Number: PB83-154815

\$160

##### User Representative

Scientific and Technical Information Branch

National Center for Health Statistics

Center Building, Room 1-57

3700 East-West Highway

Hyattsville, MD 20782

(301) 436-8500

##### Order Point:

National Technical Information Service

5285 Port Royal Road

Springfield, VA 22161

(703) 487-4650

#### TAPE CHARACTERISTICS

##### Density

800, 1600 or 6250 bpi.

##### Number of Tracks

Nine.

##### Magnetic Recording Code

EBCDIC.

##### Preformatted

No.

##### Data Structure

Rectangular.

##### Technical Documentation

*Plan and Operation of the HANES I Augmentation Survey of Adults 25-74 years, United States, 1974-1975.* Hyattsville, MD: National Center for Health Statistics, June 1978.

*Plan and Operation of the Health and Nutrition Examination Survey, United States, 1971-1973.* Rockville, MD: National Center for Health Statistics, January 1977.

McDowell, Arthur, Engel, Arnold, Massey, James T., Maurer, Kurt. *Plan and Operation of the Second National Health and Nutrition Survey, 1976-1980. Vital and Health Statistics, 1 (15), 1981.*

Miller, H. and Williams, P. *Factors Related to Response in a Health Examination Survey, United States 1960-1962. Vital and Health Statistics, 2 (36), August 1969.*

# SURVEY EVALUATION

## Narrative Assessment

This survey only captures physical impairments. In most cases, functional limitations can only be related to a physical impairment generally; the specific impairment is not identified.

## Prior Users and Use Reports

Evans, R. *Present Evidence on Mortality and Morbidity of Asthma*. Paper presented at the Fogarty International Center, Washington, DC, June 1985.

# THE 1978 SURVEY OF DISABILITY AND WORK

## CONTACT

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Division of Disability Studies  
Office of Disability  
Social Security Administration  
6401 Security Boulevard  
Room 2223, Annex Building  
Baltimore, MD 21235  
(301) 594-0300

## SPONSOR

Social Security Administration.

## PERIOD

July—September 1978.

## SURVEY DESCRIPTION

### Survey Objectives

To assess the public's knowledge of government programs in the area of disability;

To examine work incentives and income adequacy as they affect a disabled person's inclination to apply for benefits or to return to the labor force once on the rolls;

To construct more precise and accurate measures of functional limitation and severity of disability;

To update estimates of the prevalence of disability in the working age population.

### Population Surveyed

Adults living in U.S. households and persons denied and receiving Social Security Disability Insurance benefits.

## Survey Size

11,739 persons.

## Survey Design

The 1978 survey is a national sample of civilian noninstitutionalized adults aged 18-64.

The survey consists of a total sample of 11,739 persons comprised of two separate panels. The first is a sample selected from the 1976 cohort of the Health Interview Survey. The second is based on two samples drawn from Social Security Administration records: applicants for disability benefits who were denied in January-September 1977 and disability insurance (DI) beneficiaries whose entitlement began within the 5 years prior to September 1977. Of the total sample, approximately 6,900 are selected from the HIS, 4,500 from recent DI beneficiaries, and 500 from recent DI denials.

## Data Source

Household interviews conducted by the Bureau of the Census from July through September 1978.

## Estimation (Case Weighting) Scheme

Cases from the Social Security Administration (SSA) and Health Interview Survey (HIS) sampling frames have separate case weights to permit separate analyses as appropriate. The case weights consist of a basic weight (the reciprocal of the probability of case selection) and a non-interview adjustment weight.

## Response Rates

<i>Interview Status</i>	<i>Total</i>		<i>HIS Frame</i>		<i>SSA Frame</i>	
	<i>Number</i>	<i>Percent</i>	<i>Number</i>	<i>Percent</i>	<i>Number</i>	<i>Percent</i>
All cases	11,739	100.0	6,883	100.0	4,886	100.0
Completed interview	9,859	83.7	5,652	82.1	4,207	86.1
Noninterview	1,880	16.3	1,201	17.9	679	13.9

## Treatment of Missing Values

Most missing values are imputed using a procedure explained in technical documentation available on request. The specific items imputed are identified on a special tape also available on request.

## Sampling Error

Standard error tables are developed for the combined HIS/SSA sample estimates and for each sample alone. Representative standard errors of estimated numbers of persons from the combined HIS and SSA samples are as follows:

<i>Estimates</i>	<i>Total Disabled Persons-Standard Error</i>	<i>Severely Disabled Persons-Standard Error</i>
50,000	37,000	39,000
10,000,000 +	459,000	452,000

## KEY VARIABLES AND VARIABLE BREAKDOWNS

### Age

Age in years from 0 to 99.

### Race/Ethnicity

Race: White; Black; Asian or Pacific Islander; American Indian, Aleutian, Eskimo; other.

Ethnic Origin: German, Italian, Irish, French, Polish, Russian, English, Scottish, Welsh, Mexican-American, Chicano, Mexican, Mexicano, Puerto Rican, Cuban, Central or South American country, other Spanish, Black/Negro, another group.

### Family Income

Work earnings: \$0-30,000, over 30,000.

Spouse's work earnings: \$0-30,000, over 30,000.

Other relatives' work earnings: \$0-30,000, over 30,000.

Other income by source: (e.g., roomers or boarders, apartment rent or other real estate, interest or dividends, Social Security, Supplemental Security Income, etc.), \$0-30,000, over 30,000.

Income Recode: \$3,000 or less; 3,000-3,999; 4,000-4,999; 5,000-5,999; 6,000-7,499; 7,500-9,999; 10,000-11,999; 12,000-14,999; 15,000-19,999; 20,000-24,999; 25,000-29,999; 30,000-39,999; 40,000-49,999; 50,000 and over.

## **Employment Status**

Reported.

## **Rural/Urban Residence**

Urban, rural.

## **Disabling Conditions/Functional Limitations**

Does your health or condition limit the kind or amount of work you can do?

Does your health or condition keep you from working altogether?

Does your health or condition limit the kind or amount of work you can do around the house?

Are you now able to do the same kind of work you did before your work limitation began?

Are you now able to work full time or can you work only part time?

Are you now able to work regularly or can you only work occasionally or irregularly?

Main reason (health condition classified according to International Classification of Diseases, 8th revision) for work limitation.

Mobility: stay in bed all or most of the time, get out of bed for personal needs, chairbound all or most of the time, go out of doors without help, able to use public transportation without help, have driver's license, condition prevents driving a car.

Activity limitations: walk for a long distance, use stairs or incline, stand for long periods, sit for long periods, stoop, crouch or kneel, reach, use fingers to grasp or handle, lift or carry something as heavy as 10 pounds, lift or carry something as heavy as 25 pounds, lift or carry something as heavy as 50 pounds.

## **Family Composition**

Relationship of other family members to sample respondent: brother/sister, other relative, nonrelative, spouse, own child under age 18, own child 18 years and older, son-in-law/daughter-in-law, father/mother, parent-in-law.

## **Beneficiary Status for Major Federal Programs**

Social Security, Supplemental Security Income, Railroad Retirement Benefits, Veterans Administration benefits, unemployment compensation, workers' compensation, Aid to Families with Dependent Children, public welfare, Civil Service, other.

## **Other Health Related Data**

Reported.

## **Other Demographic Data**

Education, marital status.

## **Geographical Area**

State:

Not reported.

Region:

Northeast, North Central, South, West.

SMSA:

Not reported.

#### Service Utilization

##### Types of Service

Medical, job training, rehabilitation.

##### Level of Utilization

Reported.

#### AVAILABILITY OF DATA

##### Price of Data or Tapes

\$255.

##### User Representative

Sylvan Hack  
Division of Disability Studies  
Office of Disability  
Social Security Administration  
6401 Security Boulevard  
Baltimore, MD 21235  
(301) 594-0708

#### TAPE CHARACTERISTICS

##### Density

1600 bpi.

##### Number of Tracks

Nine.

#### Magnetic Recording Codes

EBCDIC.

#### Prformatted

No.

#### Data Structure

Rectangular.

#### Technical Documentation

*Users Manual for the 1978 Survey of Disability and Work.* Social Security Administration, June, 1981. (SSA Pub. No. 13-11732).

Bye, Barry V. and Sallicchio, Sal. *A Note on Maximum Likelihood Estimation of Discrete Choice Models from the 1978 Survey of Disability and Work.* Office of Research and Statistics Working Paper No. 28. Baltimore: Social Security Administration, November 1982.

Bye, Barry and Schechter, Evan. *A Technical Introduction to the 1978 Survey of Disability and Work.* Social Security Administration, Office of Research and Statistics, January 1982. (SSA Pub. No. 13-11745).

Thelen, Wendi. *Technical Memorandum: Reinterview Results for the 1978 Disability Survey.* Washington: Department of Commerce, Bureau of the Census, July 31, 1979.

#### SURVEY EVALUATION

##### Narrative Assessment

The overall noninterview rate is about 16 percent. While the noninterview rate appears to be high, it includes noninterview reasons such as exclusion due to travel restrictions and exclusion due to out-of-scope age, in addition to standard reasons such as refusal, unable to contact, deceased or institutionalized.



The survey includes only persons ages 18 to 64 living in households and group quarters. The stratification of the sample does not permit state-specific estimates to be derived.

Information is included on the duration of the disabling conditions, past and future (expected). Unlike many disability surveys, persons with mental as well as physical disabilities can be identified.

### **Prior Users and Use Reports**

Burdette, Mary Ellen and Baker, Shirley. *Work Disability in the United States: A Chartbook*. Washington: Social Security Administration, December 1980. (SSA Pub. No. 13-11978).

Lando, Mordechai, et al. *1978 Survey of Disability and Work Data Book*. Baltimore: Social Security Administration, 1983.

## **SURVEY OF INCOME AND PROGRAM PARTICIPATION (SIPP), WAVE THREE QUESTIONNAIRE**

### **CONTACT**

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### **SPONSOR**

Bureau of the Census.

### **PERIOD**

The Third Wave is part of an ongoing survey begun in October of 1983. The survey consists of yearly samples or "panels" interviewed at four-month intervals over a two and one half year period. Third Wave respondents were interviewed from May to August, 1984. Respondents are asked to provide information about the four months prior to the interview month, except for certain sections which may have longer reference periods.

### **SURVEY DESCRIPTION**

#### **Survey Objectives**

This is a survey of the economic situation of people in the United States, designed to: 1) provide data for a better understanding of the income distribution in the United States, 2) study Federal and State income transfer and service programs to estimate future program costs and coverage, and to assess the effects of proposed changes in program eligibility rules or benefits levels, and 3) to

provide information for debating policy issues such as national pension and retirement plans, tax reform, social security funding and health care reform.

### Population Surveyed

Persons age 15 and over living in U.S. households.

### Survey Size

Approximately 25,000 designated households comprise the core 1984 panel sample; an additional 18,000 designated households comprise a second overlapping panel introduced in February of 1985.

### Survey Design

The SIPP sample design for the 1984 panel consists of about 25,000 housing units selected to represent the noninstitutional population of the United States of which about 21,000 were occupied and eligible for interview. The sample households within the 1984 panel are divided into four subsamples of nearly equal size. These subsamples are called rotation groups and one rotation group is interviewed each month. Each household in the sample is scheduled to be interviewed at four-month intervals over a period of two and one half years beginning in October 1983. The reference period for the questions is the four-month period preceding the interview. For example, households interviewed in October are asked questions for the months of June, July, August, and September. This household is interviewed again in February 1984 for the October through January period.

In general, one cycle of interviews covering the entire sample and using the same questionnaire, is called a wave. Only the Third Wave (which began in May 1984) contains disability-related information, asked in a "topical module" appended to the core questionnaire.

A new panel of slightly smaller size is scheduled to be introduced in February 1985 and in February of each suc-

ceeding year. This overlapping design will provide a much larger sample size (almost twice as large) from which cross-sectional estimates can be made. The overlap will also enhance the survey's ability to measure change by lowering the standard errors on differences between estimates for two points in time.

### Data Source

Interviews from the Census Bureau regional offices conduct a personal interview with each sampled household every four months. Every household member age 15 or older who is present is asked to provide information about him/herself; if absent, a proxy provides this information. Telephone interviewing is used only in the following cases: 1) to obtain missing information, 2) to interview persons who could not or would not participate otherwise, and 3) to interview persons who have moved more than one hundred miles from the SIPP sampling unit.

### Estimation (Case Weighting) Scheme

Weighting for each case is the product of five factors:

- 1) For Wave 1, the inverted probability of selection is used to achieve an unbiased estimation of levels and proportions in the absence of non-response. For subsequent waves this factor is decreased for housing units that have members who were not part of the original sample.
- 2) Adjustment to reflect subsampling occasionally implemented in the field.
- 3) Adjustment for household non-response.
- 4) Post-stratifying within region by metropolitan status and race in 1980 to reduce the variance between primary sampling units.
- 5) An iterative ranking procedure to: a) reduce mean square error of estimates of characteristics of per-

sons correlated with age, race or sex, and b) reduce variance on estimates related to type of household (i.e., marital and family status of household(ers) by race and sex).

### Response Rates

Eighty-eight percent of all Wave 1 respondents are retained and interviewed for Wave 3.

### Treatment of Missing Values

Missing values are imputed using the “sequential hot deck” procedure, whereby data for unanswered survey questions are allocated by copying data from the last case processed with similar characteristics.

### Sampling Error

Estimates of disability on the Wave Three topical module have not been released yet. Directions for calculating standard errors for SIPP data are provided in Current Population Reports (Series P-70).

An estimate of 15,029,000 persons in nonfarm households during the first quarter of 1984 has a standard error of 529,000.

## KEY VARIABLES AND VARIABLE BREAKDOWNS

### Age

Age in years as of last birthday.  
Month and year of birth.

### Race/Ethnicity

Race: White; Black; American Indian, Eskimo or Aleutian; Asian or Pacific Islander.

Ethnic Origin: 23 categories (including Spanish origin categories).

### Family Income

Data are compiled on nearly 50 different sources of income including transfer payments and non-cash benefits. In addition, data will be compiled on assets. Income is coded as reported (no intervals).

### Employment Status

Reported.

### Rural/Urban Residence

In metropolitan subsample, not in metropolitan subsample. Metropolitan is coded for areas with a population of 250,000 or more. In addition, some nonmetropolitan areas are grouped with metropolitan areas, with the remainder coded as residual or nonmetropolitan.

### Disabling Conditions/Functional Limitations

Does . . . have a physical, mental, or other health condition which limits the kind or amount of work . . . can do? (core questionnaire item).

Does . . . have any difficulty seeing words and letters in ordinary newspaper print even when wearing glasses or contact lenses if . . . usually wears them?  
Is . . . able to do this at all?

Does . . . have any difficulty hearing what is said in a normal conversation with another person? (using a hearing aid if . . . usually wears one)  
Is . . . able to do this at all?

Does . . . have any trouble having his/her speech understood?

Does . . . generally use an aid to help . . . get around such as crutches, a cane, or a wheelchair?

Does . . . have any difficulty lifting and carrying something as heavy as 10 pounds, such as a full bag of groceries?

Is . . . able to do this at all?

Does . . . have any difficulty walking for a quarter of a mile—about three city blocks?

Is . . . able to do this at all?

Does . . . have any difficulty walking up a flight of stairs without resting?

Is . . . able to walk up a flight of stairs without the help of another person?

Does . . . have any difficulty getting around outside the house by . . . self?

Does . . . have any difficulty getting around inside the house by . . . self?

Does . . . need the help of another person in order to get around inside the house? Outside the house?

Does . . . have any difficulty getting into and out of bed by . . . self?

Does . . . need the help of another person in order to get in and out of bed?

What health condition is the main reason . . . has trouble getting around?

Arthritis of rheumatism, back or spine problems (including chronic stiffness or deformity of the back or spine), blindness or vision problems (difficulty seeing well enough to read a newspaper even with glasses on), cancer, deafness or serious trouble hearing, diabetes, heart trouble (including heart attack [coronary]), hardening of the arteries [arteriosclerosis]), hernia or rupture, high blood pressure, kidney stone or chronic kidney trouble, lung or respiratory trouble (asthma, bronchitis, emphysema, respiratory allergies, tuberculosis or other lung trouble),

mental illness, mental retardation, missing limb (legs, feet, arms, hands, or fingers), nervous or emotional problems (or alcohol or drug problems), paralysis of any kind, senility, stiffness or deformity of limbs (foot, leg, arm or hand), stomach trouble (including ulcers, gallbladder or liver condition), stroke, thyroid trouble or goiter, tumor (cyst or growth), other (specify).

Does . . . need help to do housework/prepare meals?

What health condition is the main reason . . . is unable to (do housework/prepare meals)?

Same as above list.

Does . . . need help from others in looking after personal needs such as dressing, undressing, eating, or personal hygiene?

## Family Composition

Type of Family:

Primary family (a group of two persons or more, one of whom is the householder, related by birth, marriage or adoption and residing together, including related sub-family members)

Sub-family (a married couple with or without children, or one parent with one or more of own children, single, never married children under 18, living in a household and related to, but not including the person or couple who maintains the household)

Secondary family (group of two persons or more who are related to each other by birth, marriage or adoption, but who are not related to the householder)

Primary individual or nonfamily householder (a person maintaining a household while living alone or with nonrelatives only)

Secondary individual (a person in a household or group quarters such as a guest, roomer, boarder, or resident employee [excluding nonfamily householders and inmates of institutions] who is not related to any other person in the household or group quarters).

Kind of Family:

Headed by husband/wife, male reference person, female reference person.

Number of persons in family.

Number of own children.

### **Beneficiary Status for Major Federal Programs**

Extensive information is gathered for each respondent (all household members age 15 and older) including: Veterans Administration benefits; Social Security benefits; other health benefits (e.g., black lung); food stamps; Aid to Families with Dependent Children; Aid to Women, Infants and Children; general assistance; Medicaid; GI Bill; Pell Grant; Guaranteed Student Loan; National Direct Student Loan; Medicare; work training (e.g., CETA, WIN).

### **Other Health Related Data**

Not reported.

### **Other Demographic Data**

Sex, marital status, education.

### **Geographical Area**

State:

Reported (38 individual states).

Region:

Regional estimates can be derived.

SMSA:

Selected metropolitan statistical areas (MSA) and consolidated metropolitan statistical areas (CMSA) are identified where the 1982 population within SIPP PSU's exceeds 250,000.

### **Service Utilization**

#### **Types of Services**

Help with ambulation, personal care, and household tasks; hospitalizations; physician or assistant contacts.

#### **Level of Utilization**

Reported for some.

### **AVAILABILITY OF DATA**

Data tapes based on the Wave Three questionnaire are available.

#### **Price of Data or Tapes**

9 reels (1600 bpi): \$1,260.

3 reels (6250 bpi): \$420.

#### **User Representative**

Dave McMillen  
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Order Point:

Paul Zeisset  
Customer Service Branch  
Data User Services Division  
Bureau of the Census  
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## TAPE CHARACTERISTICS

### Density

1600 or 6250 bpi.

### Number of Tracks

Nine.

### Magnetic Recording Codes

ASCII or EBCDIC.

### Preformatted

No.

### Data Structure

Rectangular or hierarchical.

### Technical Documentation

Nelson, Dawn, McMillen, David, Kasprzyk, Daniel. *An Overview of the Survey of Income and Program Participation*. Working Paper Series No. 8401. Washington: Bureau of the Census, June 1984.

*Survey of Income and Program Participation (SIPP) Wave 3 Rectangular Microdata File Technical Documentation*. Washington: Bureau of the Census, 1985.

*Survey of Income and Program Participation (SIPP) User's Guide*. Washington: Bureau of the Census, undated.

*Interviewers' Manual (1984) Survey of Income and Program Participation*. Washington: Bureau of the Census, 1984.

## SURVEY EVALUATION

### Narrative Assessment

SIPP is an extraordinarily involved survey with a complex design, requiring a fairly sophisticated knowledge of data analysis to extract information that is of interest. It includes questions on disability with detailed functional as well as categorical components.

### Prior Users and Use Reports

Two types of reports are planned by the Census Bureau:

- (1) Quarterly and annual reports focusing on the core questionnaire, for example:

*Average Monthly Data from the Survey of Income and Program Participation*. Washington: Bureau of the Census (in preparation).

- (2) Periodic reports based on the topical modules.



# VETERANS ADMINISTRATION COMPENSATION AND PENSION MASTER FILE

## CONTACT

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## SPONSOR

Veterans Administration.

## PERIOD

The file contains information on current payees based upon their application for benefits and any subsequent income reviews (annual) or disability reviews (scheduled depending on the case).

## SURVEY DESCRIPTION

### Survey Objectives

The file is maintained to pay Veterans benefits, and secondarily to identify particular categories of claimants, to produce name/address lists, etc.

### Population Surveyed

This is not a survey; however, the file contains data on all Veterans benefit payees including veterans, widows, parents, children, and other beneficiaries.

### Survey Size

Approximately 4.5 million payees, of which about two to three million are veterans.

### Survey Design

Not applicable.

### Data Source

Information is gathered from the claimant, service medical records, and other agencies (e.g., Social Security).

### Estimation (Case Weighting) Scheme

Not applicable.

### Response Rates

Not applicable.

### Treatment of Missing Values

Not applicable.

### Sampling Error

Not applicable.

## KEY VARIABLES AND VARIABLE BREAKDOWNS

### Age

Date of birth.

### Race/Ethnicity

Not reported.

### Family Income

Income (solicited annually) is available. For those enrolled under the current pension law (enacted 1/1/79), complete income data are reported. Under previous pension laws, not all sources of family income are included.

### Employment Status

Not reported.

### Rural/Urban Residence

Not reported.

### Disabling Conditions/Functional Limitations

A four-digit diagnostic code from the Schedule for Rating Disabilities (a 1945 rating schedule containing several hundred diagnostic codes) is assigned, along with a percentage rating of level of disability in 10 percent increments. Ratings are grouped for the purposes of the 1984 *Annual Report* into (1) Psychiatric and Neurological Diseases, and (2) General Medical and Surgical Conditions.

### Family Composition

Records reflect family composition to the extent that additional benefits are paid to dependents. In the case of compensation, dependents are paid if the veteran's disability rating is 30 percent or greater.

### Beneficiary Status for Major Federal Programs

Veterans benefits only.

### Other Health Related Data

Not reported.

### Other Demographic Data

Address, marital status (if dependents are being paid), sex (not a required field, however about 99% of recipients are male).

### Geographical Area

State:

Can be determined based on zip code.

Region:

Not reported.

SMSA:

Not reported.

### Service Utilization\*

Not reported.

## AVAILABILITY OF DATA

Public use tapes are not routinely available. Release of tapes, special analyses or internal reports may be arranged with clearance from the Veterans Administration. Such requests ordinarily must show adequate justification and benefits for veterans' interests, before the VA will honor the request. Sponsorship of a request by another government agency typically enhances the chance of obtaining data.

### User Representative

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## TAPE CHARACTERISTICS

### Density

1600 or 6250 bpi.

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\*Service use data are available on an entirely separate Veterans Administration file, the Patient Treatment File.

**Number of Tracks**

Nine.

**Magnetic Recording Codes**

EBCDIC.

**Performatted**

No.

**Data Structure**

Rectangular.

**Technical Documentation**

Not available. The Veterans Administration provides descriptions of all fields contained in any tape prepared and released in response to a special request.

**SURVEY EVALUATION****Narrative Assessment**

A limitation to these data is that disabilities are coded according to a somewhat outdated, non-standard rating system.

**Prior Users and Use Reports**

Table 62: Disability, Degree of Impairment, Type of Major Disability, Period of Service. *Annual Report 1984*. Washington: Veterans Administration, September 1984.

## BIBLIOGRAPHY: ANNOTATED REFERENCES

\_\_\_\_\_. *Characteristics of Social Security Disability Insurance Beneficiaries*. Washington: Social Security Administration, Office of Research, Statistics and International Policy, November 1983.

This report presents data that identify and highlight basic characteristics of those disabled workers whose claims for benefits were allowed during calendar years 1977-79, inclusive. The data presented include the age, sex, occupation, diagnosis, mobility, and state of residence of workers allowed benefits during the period. The data base was a sample of disability decisions made during 1977-79.

\_\_\_\_\_. Health Interview Survey Procedure: 1957-1974. *Vital and Health Statistics*, 1 (11), April 1975.

This report outlines the changes that have led to the improvement of data collection in the Health Interview Survey since its inception in 1957. Statistical design, estimating procedures, reliability of estimates, errors due to sampling variability, and questionnaire development are reviewed. Copies of the questionnaire and rotating supplements are included.

\_\_\_\_\_. *Report of the Subcommittee on Definition of Neurological Impairments*. Albany, NY: The New York State Advisory Council on Mental Retardation and Developmental Disabilities, October 1980.

A subcommittee of the New York Advisory Council on Mental Retardation and Developmental Disabilities prepared this report summarizing their recommendations regarding the appropriate definition of neurological impairments. Issues relating to the impact of existing definitions are discussed and a new definition is recommended. This definition utilizes a functional rather than categorical description. Summary recommendations are presented including: use of the International Classification of Diseases to provide a framework for the identification and classification of specific neurological impairments; a process for client diagnosis and assessment; increase in prevention activities; and adoption of a functional definition of developmental disabilities.

\_\_\_\_\_. Report of the Twentieth Anniversary Conference of the United States National Committee on Vital and Health Statistics. *Vital and Health Statistics*, 4 (13), September 1970.

This is a discussion of three problems in the gathering and use of health statistics: guaranteeing the basic rights of individual data sources; determining current needs for these data; and indicating ways in which National Committees can contribute to their development.

\_\_\_\_\_. *Selected Data from the Census Disability Survey Pretest*. Washington: Bureau of the Census, October 1981.

This report presents data drawn from a pretest of a survey of characteristics of the disabled population which was planned as a follow up to the decennial census. The pretest was conducted in 1980 in Richmond, Virginia. Of the 1,984 households designated for interview, 992 contained at least one disabled person who was later interviewed; the other 992 households had no disabled persons. Tables are presented according to type of limitation or disability and by age, sex, race, labor force status, characteristics of current job, depression and health status, need for housing modifications, use of furniture, receipt of rehabilitation services and their perceived benefits, and ability to use selected forms of transportation. Also presented are statistics on the use of special aids and on the results of a small reinterview.

American Psychiatric Association, Committee of Nomenclature and Statistics. *Diagnostic and Statistical Manual of Mental Disorders*, Edition 3. Washington: American Psychiatric Association, 1980.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-III) is the official classification manual of mental disorder diagnostic categories of the American Psychiatric Association. Designed to be compatible with the International Classification of Diseases, the manual presents descriptors and criteria of disorders and a multi-axial method for coding. This third edition of the manual provides a new classification and glossary that reflects the most current state of knowledge regarding mental disorders.

Andersen, R., Kasper, J. and Frankel, M.R. *Total Survey Error*. San Francisco: Jossey-Bass, Inc., 1979.

This collection of essays explores the validity and reliability of data collected in a large national survey of health care use and expenditures. It describes one effort to measure the impact of bias from nonsampling sources and provides an operational, quantifiable definition of the concept of total survey error. Part I describes the model of total survey error. Part II evaluates the effects of several types of errors

in estimates made in a variety of social services and health care settings. Part III describes alternatives to the approaches used to assess bias, and Part IV reviews findings and suggests implications for survey research.

Ashbaugh, John W. A Method for Estimating the Chronic Mentally Ill Population in State and Local Areas. *Hospital and Community Psychiatry*, 36 (4), 389-393, April 1985.

A practical method for estimating the size of the noninstitutionalized chronic mentally ill population in state and local areas, including those not currently receiving services, has been developed. The method relies on national and state counts by zip code area of persons receiving Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) because of mental illness, and on full or sample counts by SSI and SSDI status of chronic mentally ill persons in publicly funded community mental health programs.

Bailar, Barbara A., Herriot, Roger A., and Passel, Jeffrey S. The Quality of Federal Censuses and Surveys. *Review of Public Data Use*, 10, 203-218, 1982.

Data collected in Federal censuses and surveys are used for a variety of purposes, two prime uses being the generation of policy and the fulfillment of legal mandates. Quality is evaluated first in terms of the coverage of certain universes since many public programs are dependent on the size of certain groups. Quality is also assessed in terms of the variances, biases, and timeliness of specific data items including income, and ethnicity.

Baum, Herbert and Goldstein, Murray. Cerebrovascular Disease Type Specific Mortality: 1968-1977. *Stroke*, 13 (6), 810-813, 1982.

Death certificates for the period 1968-1977 were examined to determine the trend, in the United States, of cerebrovascular disease death rates by type of event and demographic subgroup. The largest declines were for hemorrhagic strokes and among nonwhites. The number of hemorrhagic stroke deaths declined by 45 percent and the age-adjusted rate declined by 53 percent. Similar figures for nonwhites were 18 percent and 36 percent, respectively. It was surprising to note that the number of cerebrovascular deaths reported as poorly defined rose by 17 percent. Data on hypertension were examined. The possibility that the results with respect to hypertension are artifactual indicates

the need for clinical studies that will examine the relationship between hypertension and cerebrovascular disease mortality.

Baum, Herbert, M. and Rothschild, Beth B. Multiple Sclerosis and Mobility Restriction. *Archives of Physical Medicine and Rehabilitation*, 64, 591-596, December 1983.

Examination of mobility restriction among multiple sclerosis (MS) patients and its relationship to selected disease and demographic characteristics was undertaken using data gathered in the National Multiple Sclerosis Survey. Whether and where an individual needed assistance and the types of assistance needed were the dependent variables. These data were cross tabulated with the following patient characteristics: sex, race, educational level, region of residence, age on prevalence day, marital status, awareness of diagnosis, diagnostic code, duration of disease and age at first diagnosis. More than half of the patients reported needing assistance both indoors and outdoors. Significant factors relating to increased percentages needing assistance were as follows: longer duration, older at the time of first diagnosis, admitted awareness of the diagnosis, currently unmarried, nonwhite, and a "probable" MS diagnostic code. Most patients relied on a wheelchair or a person's assistance, and few relied on crutches or leg braces.

Bean, Judy A. Estimate and Sampling Variance in the Health Interview Survey. *Vital and Health Statistics*, 2 (38), March 1974.

A method for computing variances of estimates derived from the Health Interview Survey.

Black, Ethel R. Use of Special Aids: United States, 1977. *Vital and Health Statistics*, 10 (135), October 1980.

Statistics on the distribution and use of artificial limbs, braces, crutches, canes or walking sticks, special shoes, wheelchairs, walkers, and other special aids for getting around. Based on data collected in the National Health Interview Survey in 1977.

Bloom, Barbara. Current Estimates from the National Health Interview Survey: United States, 1981. *Vital and Health Statistics*, 10 (141), October 1982.



Incidences of acute conditions, number of persons reporting limitations of activity, number of persons injured, hospital episodes, disability days, and frequency of dental and physician visits are estimated. Estimates are based on data collected in the National Health Interview Survey during 1981.

Bonham, G. S. and Corder, L. S. *National Medical Care and Expenditure Survey Household Interview Instruments. Instruments and Procedures*, 1. Washington: National Center for Health Services Research, April 1981.

This report describes the questionnaires used in the household survey, one of the three NMCES data collection components. An overview of the household survey is provided and the structure of the interviews is discussed, as well as the types of data collected for each instrument in each round of interviewing. The location of specific groups of questions among the various instruments is shown. Two household survey control forms, the reporting unit folder and the control form, are reproduced and their use in the survey is discussed. Particular attention is given to the set of core questions asked in five of six rounds of interviewing, which inquired into disability days, the use of various types of health services and associated charges and sources of payment, health insurance coverage, and health conditions. Supplements to the core questionnaire are discussed; these were generally administered once during the course of the survey and were designed to collect data on health insurance policies, employment and income, and access to care. The computer-generated summary form, which is also shown, allowed respondents to provide additional information about previously reported or omitted instances of care, insurance payments, or health insurance coverage. Permission forms for the medical provider and health insurance-employer surveys are discussed in the last section.

Bowe, Frank. *Black Adults with Disabilities. A Statistical Portrait drawn from Census Bureau Data*. Washington: President's Committee on Employment of the Handicapped, August 1983.

This publication reports upon findings from the 1981 and 1982 Current Population Survey studies conducted by the Bureau of the Census. The report covers Americans aged 16-64 years who have a work disability but who are not institutionalized. These data are analyzed by race.

Bowe, Frank. *Demography and Disability: A Chartbook for Rehabilitation*. Fayetteville, AR: University of Arkansas, Arkansas Rehabilitation Research and Training Center, 1983.

This publication highlights key findings from the 1981 and 1982 Current Population Survey of the Census. The report covers persons aged 16-64 not in institutions. The average working-age disabled American has a high school level of education, is not in the labor force, and subsists on a low level of income. Disability is more common among blacks than among whites or Hispanics, more common among males than among females, and more common among persons with low education and income levels than among those with higher levels of schooling and of income. Suggestions regarding the implications of these data are offered in the final section of this chartbook.

Bowe, Frank. *Disabled Adults in America, A Statistical Portrait drawn from Census Bureau Data*. Washington: President's Committee on Employment of the Handicapped, undated.

This publication reports upon findings from the 1980 Census and from Current Population Survey studies conducted in 1981 and 1982 by the Bureau of the Census, U.S. Department of Commerce. The report covers Americans 16 to 64 years of age who have a work disability but who are non institutionalized. This group represents 8.6 percent of the 144 million Americans of working age or slightly more than one in twelve. Disabled Americans are, on the average, much older, much less educated, poorer, and less likely to be employed, than are non-disabled Americans. They are similar in other socio-demographic respects.

Bowe, Frank. *Disabled Women in America. A Statistical Portrait drawn from Census Bureau Data*. Washington: President's Committee on Employment of the Handicapped, undated.

This publication reports upon findings from the 1981 and 1982 Current Population Survey studies conducted by the U.S. Bureau of the Census. The report covers Americans 16-64 years of age who have a work disability but who are not institutionalized. These data are analyzed by sex.

Bowe, Frank. *U.S. Census and Disabled Adults: The 50 States and the District of Columbia*. Fayetteville, AR: Arkansas Rehabilitation Services, University of Arkansas, April 1984.



This report presents a state by state breakdown of vital statistics on the disabled working-age population. Key measures are: proportions of the working-age population that are disabled, labor-force participation among disabled adults, variations between males and females on employment-related indices, interactions between race and disability, and the prevalence of transportation disabilities in the working age and over-65 populations. Eight and one half percent of all working age persons in the U.S. report one or more disabilities. One striking finding is that the fewer disabled persons per capita in a state, the higher the proportion of such persons in the labor force. The number of disabled persons within each of the ten regions varies considerably, as does participation in the labor force.

Bowering, David J. Secondary Analyses of Available Data Bases. *New Directions for Program Evaluation*, 22. San Francisco: Jossey-Bass, Inc., June 1984.

An introduction to a number of data bases currently available and useful for secondary data analysis. Instructions on how to locate them and adapt them for use are presented, as well as instructions for setting up files. An example of conducting a secondary data analysis is shown along with a case study on impact analysis using an integrated data base.

Boyd, Jeffrey, Burke, Jack, Gruenberg, Ernest, Holzer, Charles, et al. Exclusion Criteria of DSM-III. *Archives of General Psychiatry*, 41, 983-998, October 1984.

The diagnostic criteria of the third edition of the DSM-III often state that one diagnosis cannot be made if it is "due to" another disorder. Using data from the National Institute of Mental Health Diagnostic Interview Schedule, with a sample of 11,519 subjects from a community population, the researchers found that if two disorders were related to each other according to the DSM-III exclusion criteria, then the presence of a dominant disorder greatly increased the odds of having the excluded disorder. They also found that disorders which DSM-III states are related to each other were more strongly associated than disorders which DSM-III states are unrelated. However, they also found there was a general tendency toward co-occurrence, so that the presence of any disorder increased the odds of having almost any other disorder, even if DSM-III does not list it as a related disorder. They concluded that empirical studies are needed to study the assumptions underlying the use of the diagnostic hierarchy.

Bryant, F.B. and Wortman, P.M. Secondary Analysis: The Case for Data Archives. *American Psychologist*, 33 (4), 381-387, 1978.

It is becoming increasingly important for psychologists to archive their research data so that they can be reexamined and reanalyzed by others. The utility of such secondary analysis rests on the growing cost, complexity, and social significance of psychological research; its value for the field has already been demonstrated. Nevertheless, it is often difficult or impossible to obtain research data. A number of contributory reasons involve research competence, subjects' privacy, proprietary rights, and costs. Recommendations for dealing with these problems and for the establishment of data archives are presented.

Burdette, Mary Ellen and Baker, Shirley. *Characteristics of Social Security Disability Insurance Beneficiaries, 1975*. Washington: Social Security Administration, Office of Research and Statistics, December 1979.

This report presents statistical information on the kinds of people who receive Social Security disability insurance (SSDI) benefits. Statistics are presented on selected demographic, socioeconomic, and medical characteristics of persons who were allowed benefits as disabled workers during the period 1977-79, inclusive. Figures are shown for each year separately.

Colvez, Alain and Blanchet, Madeleine. Disability Trends in the United States Population 1966-76: Analyses and Reported Causes. *American Journal of Public Health*, 71 (5), 464-471, May 1981.

According to data published by the U.S. National Center for Health Statistics, disability reported among the U.S. population has increased substantially during the years 1966 to 1976. Among younger age groups, the increase in activity limitation relates to visual and hearing impairments as well as asthma. Although the U.S. population increased by 10 percent, the number of persons permanently limited in their activities because of health conditions increased by 37 percent with a much larger proportion of those disabled claiming to be unable to carry on their main activity. Changes in health survey procedures and changes in standards used by respondents to rate their health status are not believed to account for these findings. Factors which could have contributed to this trend include environmental deterioration and improved social benefits easing retirement and providing better access to the health care system. Planning agencies need

to recognize the relationships of the health care system to disability as well as to mortality.

Czajka, John L. *Digest of Data on Persons with Disabilities*. Washington: Congressional Research Service, June 1984.

This document is a compilation of both published and previously unpublished statistical data on persons with disabilities and includes such topics as impairments, work disabilities, limitation of activity, and employment. Data are presented in table and chart form. Highlights and explanatory notes accompany each table to assist the reader in interpreting the data.

Drury, T. Current Estimates from the Health Interview Survey, United States, 1975. *Vital and Health Statistics*, 10 (115), March 1977.

Estimates of incidence of acute conditions, number of persons reporting limitation of activity, number of persons injured, hospital discharges, persons with hospital episodes, disability days, and frequency of dental and physician visits. Based on data collected in the Health Interview Survey during 1975.

Eaton, William, Holzer, Charles, Von Korff, Michael, Anthony, James, et. al. The Design of the Epidemiologic Catchment Area Surveys. *Archives of General Psychiatry*, 41, 942-948, October 1984.

Several methods are used to minimize and measure error in the NIMH Epidemiologic Catchment Area program. Sampling methods involve the inclusion of group quarters such as prisons, nursing homes, and mental hospitals in the sample frame and the use of probability sampling throughout. Interviewing methods include use of identical diagnostic interview protocols, centralized training of interview supervisors, standard instructions to interviewers, and reinterview of a subsample by clinicians. Analytic methods include use of a computerized diagnostic algorithm, common estimation formulas on identically formatted data files, and estimation of exact variances that take account of the multistage sample design.

Enterline, P.E. and Capt, K.G. A Validation of Information Provided by Household Respondents in Health Surveys. *American Journal of Public Health*, 49 (2), 205-212, 1959.

This study compares individual health information provided by the individual himself and by an "eligible" household member. Findings show that the use of household respondents will result in no less disease reported. In addition there was a small but consistent underreporting on the self-completed questionnaires, particularly if a health attribute has a bad connotation.

Ezzati, Trena and McLemore, Thomas. The National Ambulatory Medical Survey 1977 Summary. *Vital and Health Statistics*, 13 (44), April 1980.

This report presents estimates of the utilization of ambulatory medical care services provided by nonfederally employed office-based physicians in the contiguous United States during 1977. The statistics are based on data collected in the National Ambulatory Medical Care Survey (NAMCS). Utilization of ambulatory medical care services is described here in terms of number and percent distribution of office visits, annual visit rates, and such measures as mean contact duration. The utilization statistics are presented in four sections: general utilization patterns; physician and practice characteristics; demographic characteristics of patients; and visit characteristics. Preceding the 1977 NAMCS results, a brief description of the scope of the survey, the source and limitations of the data, and comparisons with estimates from previous years are presented.

Feller, Barbara A. Americans Needing Help to Function at Home. *Advance Data from Vital and Health Statistics*, 92. Washington: National Center for Health Statistics, September 1983.

A statistical portrait is drawn from selected data of the Home Care Supplement to the 1979 National Health Interview Survey of the noninstitutionalized population of the U.S. who require differing types of home care services due to chronic health problems in order to live in the community. Estimates of numbers and rates of people in the community who need help are presented by the type of help needed and by age and sex. Overall, about 4.9 million adults need the help of another person in carrying out everyday activities. The need for the help of another person increases sharply with age especially among the elderly. The need for help is examined with respect to basic physical activities such as walking or dressing, home management activities such as shopping or money handling, trouble in controlling bowel movements or for adults who are bedridden.

Feller, Barbara A. Health Characteristics of Persons with Chronic Activity Limitation: United States, 1979. *Vital and Health Statistics*, 10 (137), December 1981.

Statistics on health characteristics of persons with limitation of activity due to one or more chronic conditions or impairments are compared with those persons who were reported as not limited in activity due to chronic disease or impairment. Statistics are presented on the following utilization of services characteristics: physician visits, dental visits, and short-stay hospitalization. Data on disability days, acute illnesses, and persons injured are also presented by chronic activity limitation status.

Feller, Barbara A. Prevalence of Selected Impairments: United States, 1977. *Vital and Health Statistics*, 10 (136), February 1981.

Statistics on the prevalence of impairments involving vision, hearing, speech, paralysis, absence of extremities, and orthopedic conditions by type, impact, and etiology; distributed by age, sex, race, family income, education of head of family, usual activity status, place of residence, geographic region, and associated chronic activity limitation; and based on data collected in the National Health Interview Survey during 1977.

Fishman, S. Why Uniform Reporting Systems? *Public Health Conference on Records and Statistics. The People's Health: Facts, Figures and the Future*. Washington: U.S. Department of Health, Education, and Welfare, Office of Health Research, Statistics and Technology, August 1979.

Current reporting systems do not permit the establishment of case mix indices nor payment on the basis of diagnoses, both of which are necessary for a hospital cost containment law. There is much duplication of data among different sources. Uniform reporting systems may solve these problems, help explain broad discrepancies in charges for the same illness, and raise better questions about the delivery of health services.

Freedman, Daniel. Psychiatric Epidemiology Counts, Editorial. *Archives of General Psychiatry*, 51, 931-933, October 1984.

A positive appraisal of the NIMH Epidemiologic Catchment Area program is given: its history, purpose, findings and importance. Methodological problems and prospects for further research are

reviewed. The importance of epidemiologic research to general psychiatric research is considered as is the accuracy and utility of the data from this program.

Gallin, R.S. and Given, C.W. The Concept and Classification of Disability in Health Interview Surveys. *Inquiry*, 13 (4), 395-407, December 1976.

Given the accumulation of methods to solve the problems of disease and the need for comparative data on disability, the authors have reviewed the classification systems of disability from several major studies. The purpose of this review is to: 1) compare these classifications and measurement schemes; 2) describe the ways in which they have been influenced by different purposes; 3) discuss their advantages and disadvantages; and 4) provide information that will advance understanding of the use of the concept of disability as a measure of health. The review is organized into two sections. In the first section the authors consider classification systems that describe the general effects of illness or injury. In the second section they consider classification systems that describe the specific effects of long-term or chronic conditions. This second section is subdivided into three parts to permit categorization of different systems for classifying long-term disability. In the first part, classification systems are considered that describe the extent to which individuals are limited in their ability to carry on the major activity considered appropriate for their age and/or sex. In the second part, classification systems are considered that describe the extent to which individuals are limited in walking, mobility, and/or their ability to perform self care activities. In the third part the authors consider a system that combines measures of activity or functional capacity with categories of disease.

Gardocki, Gloria J., McLemore, Thomas, and Delozier, James E. The National Ambulatory Medical Care Complement Survey: United States, 1980. *Vital and Health Statistics*, 13 (77), May 1984.

The objective of the National Ambulatory Medical Care Complement Survey was to measure the volume and characteristics of ambulatory patient visits made to physicians not included in the National Ambulatory Medical Care Survey (NAMCS). These were physicians whose principal activity was classified as teaching, research, administration, hospital-based patient care or otherwise out of the scope of the NAMCS. Data presented include demographic, diagnostic, and therapeutic information on patients making visits to these physicians.



Gentile, Augustine. Disability Days: United States, 1974. *Vital and Health Statistics*, 10 (118), June 1978.

Statistics are presented on the number of days of restricted activity and bed disability per person year, days lost from school per school-age child 6-16 years old per year. The rates of disability days are presented by age, sex, race, place of residence, geographic region, family income, usual activity status, employment status, industry, and occupation. This report is based on data collected in household interviews during 1975.

Gollay, Elinor. *Summary Report on the Implications of Modifying the Definition of a Developmental Disability*. Washington: U.S. Department of Health and Human Services, Administration on Developmental Disabilities, June 1981.

This report explores the implications of changing the definition of a developmental disability. Key findings from an analysis of the Survey of Income and Education are presented with respect to the size and characteristics of the developmentally disabled population in the U.S. Key aspects of attempting to operationalize the definition of a developmental disability are presented. Major conditions that have been identified as potentially leading to a developmental disability under the "new" definition that generally were not covered under the previous definition are also discussed.

Haupt, Barbara. 1982 Summary: National Hospital Discharge Survey. *Advance Data from Vital and Health Statistics*, 95. Washington: National Center for Health Statistics, December 1983.

This report presents statistics on the utilization of short-stay, non-Federal hospitals. Data presented are based on the National Hospital Discharge Survey for 1982. Data highlights include: utilization by patient and hospital characteristics, utilization by diagnosis, and utilization by procedures. Tables are presented by sex and age.

Hochstim, J.R. A Critical Comparison of Three Strategies of Collecting Data from Households. *Journal of the American Statistical Association*, 62 (319), 976-989, 1967.

Returns and findings from three strategies of data collection are compared. Each strategy contains personal interviews, telephone interviews, and mail questionnaires in different combinations—one mainly

personal, one mainly telephone, and one mainly mail. All three strategies are based on area probability samples of households in Alameda County, California. The test was made in two separate studies, with identical questionnaires used in all strategies within each study. The responses from all the three strategies were found to be highly comparable. Rate of return and rate of completeness of questionnaires were high for all three; substantive findings were virtually interchangeable and there was little difference in validity. The only important difference was cost per interview, which varied considerably by strategy.

Interagency Statistical Committee on Long-Term Care for the Elderly. *Inventory of Data Sources on the Functionally Limited Elderly*. Washington: U.S. Department of Commerce, Office of Federal Statistical Policy and Standards, 1980.

This inventory lists data bases that contain information on functional limitations of elderly persons. Data bases are person-based and contain general information, information on assistance needed or received, outcome information and details on functional limitations. Most data bases are national and/or well-known. Identifying characteristics, detailed information and condensed, coded data are presented for each source.

Jack, Susan S. and Ries, Peter W. Current Estimates from the National Health Interview Survey: United States, 1979. *Vital and Health Statistics*, 10 (136), 1981.

Estimates of incidence of acute conditions, prevalence of reported chronic conditions, number of persons reporting limitations of activity, number of persons injured, hospital episodes, disability days, and frequency of dental and physician visits. Based on data collected in the National Health Interview Survey during 1979.

Jack, Susan S. Current Estimates from the National Health Interview Survey: United States, 1980. *Vital and Health Statistics*, 10 (139), 1981.

Incidence of acute conditions, number of persons reporting limitation of activity, number of persons injured, hospital episodes, disability days, and frequency of dental and physician visits are estimated. Estimates are based on data collected in the National Health Interview Survey during 1980.

Kahn, Arthur L. *Program and Demographic Characteristics of Supplemental Security Income Beneficiaries, December, 1982*. Baltimore, MD: Social Security Administration, Office of Research, Statistics and International Policy, December 1983.

Tables are presented on numbers of persons receiving Supplemental Security Income, average benefit amount, and payment distribution. Living arrangements, income, age, sex and race of SSI recipients are also shown.

Kiely, Michele and Lubin, Robert A. *Estimating the Prevalence of Persons with Developmental Disabilities in New York State*. Staten Island: New York State Institute for Basic Research in Developmental Disabilities, 1983.

An extensive literature review on the prevalence of mental retardation, autism, cerebral palsy and epilepsy is presented with special emphasis on the bases for variations in prevalence that are attributable to age, sex, level of functioning and diagnostic specificity. Also provided is a discussion of the methodological issues to consider in estimating the prevalence of developmental disabilities. This is followed by an investigation of prevalence rates of common developmental disabilities in New York State. This study utilizes a statistical technique for improving local estimates.

Kirchner, C. and Peterson, R. Estimates of Race-Ethnic Groups in the U.S. Visually Impaired and Blind Population. *Visual Impairment and Blindness, Statistical Brief 13, 74 (2), 73-76*, February 1981.

This paper presents statistical data on the prevalence of visual impairment in the U.S. by race from three data bases. The main conclusion is that the prevalence rate is higher for non-whites than for whites. Methodological issues, reasons for race differences, and the implications of those findings are pursued.

Kirchner, C. and Peterson, R. Multiple Impairments among Noninstitutionalized Blind and Visually Impaired Persons. *Visual Impairment and Blindness, Statistical Brief 7, 73 (1), 42-44*, 1980.

Data drawn from the 1977 Health Interview Survey are presented on the number and percent of noninstitutionalized visually handicapped people with other impairments. A majority of severely visually impaired persons are multiply impaired. Combinations of certain con-

ditions with special focus on deaf/blind are shown. Also discussed are the effects of aging, methodological issues, and implications of study findings.

Kirchner, C. and Lowman, C. Sources of Variation in the Estimated Prevalence of Visual Loss. *Visual Impairment and Blindness, Statistical Brief 7, 72 (8), 329-333*, 1978.

A comparison of the Model Reporting Area for Statistics on Blindness (MRA) and the National Center for Health Statistics Health Interview Survey as methods for estimating prevalence of visual loss. The MRA measures impairment as defined by the eyes' performance in standardized tests. As an objective measure it reveals a greater percentage of impairment for those under age 45, although both methods show increased prevalence with aging, especially among women. The National Center for Health Statistics Health Interview Survey is a household survey that measures disability defined functionally, i.e. whether the respondent can read newsprint. This method can be especially useful to guide outreach or program planning. Until indices are created that combine a variety of measures reflecting both ocular and individual abilities, it is recommended that at least two types of estimates be used.

Kirchner, C. and Peterson, R. The Latest Data on Visual Disability from the National Center for Health Statistics. *Visual Impairment and Blindness, 73 (6), 151-153*, 1979.

This essay presents data on "severe visual impairments" reported in the Health Interview Survey of the National Center for Health Statistics. Numbers and prevalence of impairment are presented by age, sex, income, education of head of family, place and region of residence and degree of impairment. A discussion of the stability of prevalences over six years follows.

Kramer, M. The Continuing Challenge: The Rising Prevalence of Mental Disorders, Associated Chronic Diseases, and Disabling Conditions, in Wagenfield MO. In P.V. Lemkau and B. Justice (eds.), *Public Mental Health*. Los Angeles: Sage Publishers, 1982.

This chapter presents projected changes between 1980 and 2005 in the numbers of persons with and prevalence rates of mental disorders, associated chronic disorders, disabling conditions, and the patient load

of mental health services and nursing homes. Projections are made by age, sex and race. Implications of these trends are discussed.

Lckman, J.F., Sholomskas, D., and Thompson, W.D. Best Estimate of Lifetime Diagnoses: A Methodological Study. *Archives of General Psychiatry*, 39, 879-883, 1982.

It is important for genetic, epidemiologic, and nosological studies to determine accurate rates of lifetime psychiatric diagnoses in patient and nonpatient populations. As part of a family study of major depression, lifetime psychiatric diagnoses were made for 1,878 individuals. Sources of information used in making diagnostic estimates included direct interview, medical records, and family history data systematically obtained from relatives. Diagnostic estimates were made by trained interviewers, experienced clinicians, and by computer program. The results indicate that it is possible to make lifetime, best-estimate diagnoses reliably among both interviewed and noninterviewed individuals for most diagnostic categories, and that diagnoses based on interview data alone are an adequate substitute for best-estimate diagnoses based on all available information for a limited number of diagnostic categories.

Lenski, G.E. and Legget, J.C. Caste, Class and Deference in the Research Interview. *American Journal of Sociology*, 65 (5), 453-467, March 1960.

To test the influence of the deference norm on low-status respondents when questioned by middle-class interviewers, a cross-section of Detroiters were asked their views concerning two mutually contradictory propositions used at widely separated points in the interview. As predicted, the norm led in nearly eighty percent to agree with both statements despite their highly contradictory character. This raises serious questions concerning the validity of the A-scale and concerning the interpretations of the F-scale. This study serves as yet another reminder that the research interview invariably creates a social relationship with consequences of importance for the interpretation of data.

Lindberg, Dennis. *Prevalence of Developmental Disabilities in West Virginia. Report of the West Virginia Developmental Disability Prevalence Survey Project*. Elkins, WV: Davis and Elkins College, Department of Sociology and Anthropology, July 1976.

Based on a random sample of U.S. Bureau of the Census districts and household surveys, this report projects the numbers and prevalence rates of noninstitutionalized developmentally disabled persons in West Virginia. An analysis of demographic characteristics, age distribution, proportion of persons with multiple handicaps and relationship of prevalence rates to socio-economic characteristics of the sampled districts is presented. Findings show that the developmentally disabled are not distributed uniformly throughout the state population and that members are concentrated in the younger age groups.

Lindberg, Dennis and Putnam, Joanne. *The Developmentally Disabled of West Virginia: A Profile of the Substantially Handicapped Who Are Not in Institutions. Report of the West Virginia Developmental Disability Needs Survey Project*. Elkins, WV: Davis and Elkins College, December 1979.

Socioeconomic data from the 1970 census were obtained for 59,692 West Virginians in order to estimate the prevalence of the noninstitutionalized developmentally disabled (DD) population by means of a household survey. This is a follow-up of a similar study done by the authors in 1976. Using a functional definition of developmental disability, the overall state prevalence rate of DD was 6.48 per thousand. Tables are presented on the number of functional limitations, age distribution, education, other impairments, and functional levels among the developmentally disabled as determined by use of the AAMD Adaptive Behavior Scale. Utilization of services by the developmentally disabled is examined and data indicate that there are gaps in service. Low population density may contribute to this problem and some solutions are offered.

Lubin, R., Jacobson, J. W., and Kiely M. Projected Impact of the Functional Definition of Developmental Disabilities: The Categorically Disabled Population and Service Eligibility. *American Journal of Mental Deficiency*, 87 (1), 73-79, 1982.

Indicators of substantial limitation in seven life activity areas defined in P.L. 95-602 were generated from a comprehensive needs assessment/screening instrument used in New York State. These indicators were then applied to a data base of over 35,000 individuals having one or more of the categorical developmental disabilities of autism, cerebral palsy, epilepsy, mental retardation, or other neurological impairments. Results of this analysis suggest that inclusion within the functional developmental disabilities definition of P.L. 95-602 varies



as a function of categorical disability, age, and level of intellectual functioning. Implications of these findings for access to services are discussed.

Manton, Kenneth and Baum, Herbert. CVD mortality, 1968-1978: Observations and Implications. *Stroke*, 15(3), 451-453, 1984.

In the general population, eliminating stroke as a cause of death is projected to have less impact in 1978 than in 1968, for men than for women, and for whites than for nonwhites. Tables were constructed to examine the life expectancy gains for the group of individuals who died of cerebrovascular disease. For these individuals, the gain in life expectancy at birth ranges from 9 years for white males to 18 years for nonwhite females.

McDowell, Arthur, Engle, Arnold, Massey, James, and Maurer, Kurt. Plan and Operation of the Second National Health and Nutrition Examination Survey, 1976-1980. *Vital and Health Statistics*, 1 (15), July 1981.

This report describes the planning and methods employed in the 2nd National Health and Nutrition Examination Survey (NHANES II), conducted during 1976-80. The survey covers dietary intake, medical history, detailed health examinations, and health care needs of a nationwide probability sample of approximately 21,000 persons aged 6 months-74 years. The report covers the history and planning of the survey, sample design, interview techniques, health examination procedures, quality control, and data analysis and publication plans.

McNeil, John. Labor Force Status and Other Characteristics of Persons with a Work Disability. *Current Population Reports*, P-23 (127), September 1982.

The redesign of the March Income Supplement to the Current Population Survey permitted new data to be obtained on the characteristics of the work disabled. Of the 13.1 million persons identified as work disabled, 10.4 million were due to long term physical or mental illness. There was a high correlation of disability prevalence rates and increased age, low educational attainment and lower personal income. Rates were higher among men than among women and among blacks than among Hispanics and whites respectively. Central cities of the Northeast and rural areas of the South showed higher rates as did persons who were widowed, divorced or separated. The presence of

a work disability increased the chances of being unemployed and there is a negative correlation between disability and employment. Also listed are related sources of data on work disability and attempts to account for discrepancies in reported prevalence rates.

Meltzer, J.W. and Hochstim, J.R. Reliability and Validity of Survey Data on Physical Health. *Public Health Reports*, 85 (12), 1075-1086, 1970.

The Human Population Laboratory of the California State Department of Public Health conducted two methodological studies. The first was designed to determine how consistently people answer questions about their health when a survey is repeated after a short interval. A sample of 1,530 adults completed two identical self-administered questionnaires about their disabilities, chronic illnesses, impairments and symptoms about one week apart. The chronic illnesses were the most reliably reported with a six percent drop on the second survey. Symptoms and impairments were less reliably reported with a 13 percent drop. Altogether 96 percent of the original responses were repeated on the second form showing a very satisfactory degree of reliability. The second study measures how closely information collected by survey forms agrees with that obtained from clinical records. Data on chronic physical complaints was collected by self-administered questionnaires from a probability sample of adults. A record check on respondents who had been receiving care through a prepaid health plan was conducted to investigate the extent of agreement between medical records and self reported complaints on the survey. Fifty-four percent of the chronic conditions reported by questionnaire were also reported in medical records.

Myers, J.K., Weismann, M.M., Tischler, G.L., Holzer, C.E., et al. Six-Month Prevalence of Psychiatric Disorders in Three Communities: 1980-1982. *Archives of General Psychiatry*, 41, 959-967, October 1984.

Six-month prevalence rates for selected DSM-III psychiatric disorders are reported based on community surveys in New Haven, Baltimore, and St. Louis. As part of the Epidemiologic Catchment Area program, data were gathered on more than 9,000 adults, employing the Diagnostic Interview Schedule to collect diagnostic information. The most common diagnoses for women were phobias, alcohol abuse and/or dependence, dysthymia, and major depression; the most

predominant disorder among men was alcohol abuse and/or dependence. Rates of psychiatric disorders dropped sharply after age 45.

Nagi, S.Z. An Epidemiology of Disability among Adults in the United States. *Milbank Memorial Fund Quarterly/Health and Society*, 54, 439-467, 1976.

This paper presents the findings of an epidemiological analysis of disability among adults in the noninstitutionalized continental United States. Data were collected through interviews of a probability sample of persons 18 and over, yielding 6,493 completed schedules (80.3 percent of the sample). Distinctions were made among concepts and indicators of pathology, impairment, individual performance, and social performance. Central to the analysis were two dimensions of individual performance (physical and emotional) and two dimensions of disability in social performance (work and independent living). A number of socio-demographic characteristics were included in the analysis. The results show the relative contributions of pathology and impairment to performance on the individual level, and the relative contributions of all of these factors to social performance, that is, the two dimensions of disability. Pathology, impairment performance at the individual level and socio-demographic characteristics accounted for 38 percent of the variance in work disability and 74 percent of dependence-independence in community living. Estimates of the size of populations reporting varying types and severities of disability are also presented.

Pokras, Robert and Kubishke, Kurt. Diagnosis-Related Groups Using Data from the National Hospital Discharge Survey: United States, 1982. *Advance Data from Vital and Health Statistics*, 105, January 1985.

This report presents selected estimates for 1982 of diagnosis-related groups (DRG) based on data from the National Hospital Discharge Survey. Data for this survey are sampled from short-stay non-Federal general and specialty hospitals. Statistics in this report are frequency estimates and associated average length of stay for DRG's by hospital bed size and region of the country.

Pollack, Earl. Mental Health Demographic Profile for Health Services Planning. *Statistical Notes for Health Planners*, 4. Baltimore: National Center for Health Statistics, March 1977.

To make population census data more useful for health services planning, the National Institute of Mental Health developed the Mental Health Demographic Profile System (MHDPS). The MHDPS provides data on socioeconomic status, ethnic composition, household composition and family structure, style of life, condition of housing, and community instability. This paper describes the MHDPS and gives an example of its use for mental health planning as an illustration of its application to health planning in general.

Regier, D.A., Myers, J.K., Kramer, M., Robins, L.N., et al. The NIMH Epidemiologic Catchment Area Program: Historical Context, Major Objectives, and Study Population Characteristics. *Archives of General Psychiatry*, 41, 934-941, 1984.

The National Institute of Mental Health multi-site Epidemiologic Catchment Area (ECA) program is described in the context of four previous psychiatric epidemiologic surveys which included a combined total of 4,000 subjects from Stirling County, the Baltimore Morbidity Study, midtown Manhattan study, and the New Haven third-wave survey. The ECA program is distinguished by its sample size of at least 3,500 subjects per site (about 20,000 total); the focus on Diagnostic Interview Schedule—defined DMS-III mental disorders; the one-year reinterview-based longitudinal design to obtain incidence and service use data; the linkage of epidemiologic and health service use data; and the replication of design and method in multiple sites. Demographic characteristics of community and sample populations are provided for New Haven, Baltimore, and St. Louis.

Reynolds, W.J., Rushing, W.A., and Miles, D.L. (1974). The Validation of a Function Status Index. *Journal of Health and Social Behavior*, 15 (4), 271-288, 1974.

This proposed measure of health status (Function Status Index) is based on a conception more specific than one that equates health with quality of life but is still relevant to theoretical frameworks that view health in terms of its social behavioral aspects and its relationship to social and cultural variables. Three dimensions of function status (activity, mobility and movement) are measured objectively by an interview schedule administered to 2,629 persons in two Southern Alabama counties. Content, criterion, and construct validity are assessed. Evidence is sufficiently strong to recommend use of the index to test hypotheses about social functioning and to evaluate the effectiveness of different health-care delivery systems.

Ries, P.W. Hearing Ability of Persons by Sociodemographic and Health Characteristics: United States. *Vital and Health Statistics*, 10 (140), August 1982.

This report describes the relationship between different degrees and types of hearing loss and selected sociodemographic and health-related characteristics. Data are based on a special hearing supplement included in the 1977 National Health Interview Survey. Because the same hearing scales were used in the 1971 and 1977 National Health Interview Surveys, the results of these two surveys are compared in the final section.

Robins, Lee, Helzer, John E., Weisman, Myrna, Orvaschel, Helen, et al. Lifetime Prevalence of Specific Psychiatric Disorders in Three Sites. *Archives of General Psychiatry*, 41, 949-958, October 1984.

Lifetime rates are presented for 15 DSM-III psychiatric diagnoses evaluated in three large household samples on the basis of lay interviewers' use of the Diagnostic Interview Schedule. The most common diagnoses were alcohol abuse and dependence. Disorders that most clearly predominated in men were antisocial personality and alcohol abuse and dependence. Disorders that most clearly predominated in women were depressive episodes and phobias. The age group with the highest rates for most disorders was found to be young adults (aged 25-44 years). Correlates with race, education, and urbanization are presented.

Robins, Lee. Psychiatric Epidemiology. *Archives of General Psychiatry*, 35, 697-702, June 1978.

To aid the President's Commission on Mental Health as well as the nonspecialist, the uses and developments of psychiatric epidemiology are briefly sketched. In the past few years, methods have been devised that are capable of making differential diagnoses on a lifetime basis. There is a need for instruments and tools that provide sufficiently detailed information to be of practical use. Many such developments are now within our grasp. The problems and prospects of epidemiology are discussed.

Robins, Lee, Helzer, John, Croughan, J., and Ratcliff, Kathryn. National Institute of Mental Health Diagnostic Interview Schedule. *Archives of General Psychiatry*, 38, 381-389, 1981.

A new interview schedule allows lay interviewers or clinicians to make psychiatric diagnoses according to DSM-III criteria, Feighner criteria, and Research Diagnostic Criteria. It is being used in a set of epidemiological studies. Its accuracy has been evaluated in a test-retest design comparing independent administrations by psychiatrists and lay interviewers to 216 subjects (inpatients, outpatients, ex-patients, and non-patients).

Roistacher, Richard C., Holmstrom, Engin I., Cantril, Albert H., and Chase, John T. *Toward a Comprehensive Data System on the Demographic and Epidemiological Characteristics of the Handicapped Population. Final Report*. Washington: Bureau of Social Science Research, December 1981.

This project was designed to investigate sources of available data on the incidence, prevalence, diagnostic conditions, functional limitations, and activity restrictions of the disabled population in the United States, and to design a comprehensive data system. Difficulties, both conceptual and practical in estimating incidence and prevalence are cited, including divergent data sources, varying definitions of disability and handicap, and inconsistent methodologies. Guidelines for extrapolating from existing data are given, including techniques of aggregation and merging, and linking multidimensional tables. The report recommends steps to be taken by the National Institute of Handicapped Research to improve disability statistics, including advocacy for inclusion of disability data in census and other national surveys. The development of a Disability Data Archiving and Analysis Center is detailed, and such a project's abstracting, reference, circulation, file processing, analysis, procedures, examples of user request, and administrative considerations are noted. Among five appendices are papers on machine readable data files and a selected bibliography on the definition of measurement and disability.

Schoenborn, Charlotte. Basic Data from Wave I of the National Survey of Personal Health Practices and Consequences. *Vital and Health Statistics*, 15 (2), August 1981.

This report presents data from Wave I of the National Survey of Personal Health Practices and Consequences. It is the second report on this survey in the Vital and Health Statistics series published by the National Center for Health Statistics. The survey builds upon the work of the Human Population Laboratory by looking at the health practices and the health status of U.S. adults. It is intended as a



reference document for persons interested in the study of preventive health behavior, its correlates, and its consequences, and is useful for persons interested in using the data for their own analyses.

Shapiro, S., Skinner, E.A., Kessler, L.G., Von Korff, M., et al. Utilization of Health and Mental Health Services: Three Epidemiologic Catchment Area Sites. *Archives of General Psychiatry*, 41, 971-978, 1984.

Utilization of health and mental health services by noninstitutionalized persons aged 18 years and older is examined based on interviews with probability samples of 3,000 to 3,500 persons in each of three sites of the National Institute of Mental Health Epidemiologic Catchment Area (ECA) program: New Haven, Baltimore, and St. Louis. In all three ECA's, 6 percent to 7 percent of the adults made a visit during the prior six months for mental health reasons; proportions were considerably higher among persons with recent DSM-III disorders covered by the Diagnostic Interview Schedule (DIS) or severe cognitive impairment. Between 24 percent and 38 percent of all ambulatory visits by persons with DIS disorders were to mental health specialists. In seeking mental health services, men were more likely to turn to specialists than to generalists; women used both about equally. The aged infrequently received care from mental health specialists. Visits for mental health reasons varied considerably depending on specific types of DIS disorder.

Siemiatacki, Jack. A Comparison of Mail, Telephone, and Home Interview Strategies for Household Health Surveys. *American Journal of Public Health*, 69 (3), 238-245, March 1979.

The method of data collection in household health surveys can be a major determinant of cost and data quality. A survey strategy can be comprised of telephone or home interview methods, individually or in combination, to follow up non-respondents. The purpose of this study in Montreal was to compare the cost and data quality of various strategies. Strategies that began with mail or telephone contact, followed by the two other methods, yielded response rates as high as a home interview strategy (all between 80 and 90 percent), for one half the cost of home interviews when used as the sole method. The telephone response rate was higher than the mail response rate.

Sirrocco, Al. An Overview of the 1980 National Master Facility Inventory Survey of Nursing and Related Care Homes. *Advance Data from Vital and Health Statistics*, 111, September 1985.

This report estimates the number and characteristics of nursing homes based on data collected in the National Master Facility Inventory Survey. It includes one chart and six tables showing free-standing and hospital-based nursing homes and residential facilities, numbers of beds and residents, occupancy and admission rates, residents by age and sex, and full-time equivalent RN's and licensed practical nurses (total, per home, and per bed)—all by region, 1982. Most data are shown by nursing home ownership and certification.

Spitzer, R.L., Endicott, J., and Robins, E. Research Diagnostic Criteria: Rationale and Reliability. *Archives of General Psychiatry*, 35, 773-782, 1978.

This article describes the development and initial reliability studies of a set of specific diagnostic criteria for a selected group of functional psychiatric disorders, the Research Diagnostic Criteria (RDC). The RDC are being widely used to study a variety of research issues, particularly those related to genetics, psychobiology of selected mental disorders, and treatment outcome. The data indicate that high reliable diagnostic judgments can be made using these criteria.

Stewart, Anita L., Ware, John E., and Brook, Robert H. *Construction and Scoring of Aggregate Functional Status Measures: Volume I*. Santa Monica, CA: Rand Corporation, August 1982.

In this study, the authors demonstrate that cumulative aggregate functional status scales, as opposed to other items or scales that measure specific functional status categories, are appropriate and reliable for the purpose of ranking people in general populations. This is based on scaling studies conducted in five general populations. They suggest that to adequately assess personal functioning, it is important to determine if people are limited both in the kind and amount of activities they can do. Results indicate that two types of aggregation schemes can be used, i.e., personal functioning and role functioning, and that they be scored and interpreted separately.

Storck, John. Report of the Twentieth Anniversary Conference of the United States National Committee on Vital and Health Statistics. *Vital and Health Statistics*, 13, September 1970.

Discussion of three problems in the gathering and use of health statistics: guaranteeing the basic rights of individual respondents, determining current needs for these data, and indicating ways in which National Committees can contribute to their development.

Taube, Carl A. and Goldberg, Irving D. Service Utilization Data as a Proxy Measure of Incidence and Prevalence. *The People's Health: Facts, Figures, and the Future. Public Health Conference on Records and Statistics*. Rockville, MD: Department of Health, Education, and Welfare, Office of Health Research Statistics and Technology, August 1979.

An examination of the drawbacks and advantages of the use of utilization-of-service measures of the incidence and prevalence of mental health disorders. While utilization studies often neglect the full universe of services, duplicate counts of persons, and underreport some diagnoses, these data are economical to collect and can account for conditions of low frequency. Several steps can be employed to increase this potential use of utilization data: e.g., increase the universe considered to include generic health care settings, promulgate the use of standard definitions, and conduct methodological studies on the relationship of use to true prevalence and on the relationship of person counts to duplicated counts. The last would involve the development of conversion factors, improvement in the capacity of routine management information systems to produce person data, and more intensive analysis of data files from insurance plans.

Tischler, G.L., Heinz, J.E., Myers, J.K., and Boswell, P.C. Utilization of Mental Health Services: Patienthood and the Prevalence of Symptomatology in the Community. *Archives of General Psychiatry*, 32, 411-418, 1975.

The authors explore the association between patienthood and prevalence of symptomatology in the community. Base line data on prevalence were obtained through the use of a household survey. These data were compared with data on the characteristics of survey respondents (N = 938) and patients admitted from the surveyed area to a Connecticut Mental Health Center (CMHC) during a 12-month period (N = 808). The high utilization of the CMHC was associated with the prevalence of symptoms in the community, particularly where defining characteristics were descriptors of disadvantaged social status. A second set of variables correlated with mental health center use but not with the prevalence of symptoms in the community; by and large,

these characteristics describe a lack of social supports not necessarily related to social status. Finally, certain groups were underrepresented as patients even though they comprised populations-at-risk in terms of levels of symptom impairment in the community.

Weissman, M.M. and Klerman, G.L. Epidemiology of Mental Disorders. *Archives of General Psychiatry*, 35, 705-712, 1978.

Psychiatric epidemiology in the United States is being influenced by developments in genetics, psychopharmacology, and neurobiology. These influences follow the heavy influence of the social sciences during the post-World War II period. The integration of recent scientific developments in psychiatry, with the methodological precision that characterized the earlier studies of the 50's and 60's, promises to provide new knowledge on the epidemiology of mental disorders in the community; this will have important implications both for professional practices in medicine and public health and for public policy in the planning of mental health services, training, and research.

Wilder, C. Health Characteristics of Persons with Chronic Activity Limitations: United States, 1974. *Vital and Health Statistics*, 10 (112), October 1976.

Statistics on persons limited in activity due to chronic conditions by age and sex. Statistics are presented on the utilization of physician services, hospitals, dental services, and the incidence of acute conditions and personal injury. The data were collected in health interviews in 1974.

Wilder, Charles. Disability Days: United States, 1980. *Vital and Health Statistics*, 10 (143), July 1983.

Statistics are presented on the number of days of restricted activity and bed disability per person per year, days lost from work per currently employed person 17-64 years of age per year, and days lost from school per child 6-16 years of age per year. The disability-day rates are shown by age, sex, race, place of residence, geographic region, family income, usual activity status, industry, occupation, perceived health status, chronic activity limitation, veteran status, and receipt of public assistance. Estimates are based on data collected in health interviews in 1980.

Wilder, Charles. Limitation of Activity due to Chronic Conditions: United States, 1974. *Vital and Health Statistics*, 10 (111), June 1977.

This report presents statistics on persons limited in activity due to chronic conditions by age, sex, color, family income, educational attainment, usual activity status, living arrangement, geographic region, and place of residence. Statistics are also presented on chronic conditions reported as causing limitation of activity by demographic characteristics. Estimates are based on data collected in household interviews during 1974.

Wilder, Charles S. Prevalence of Selected Impairments: United States, 1971. *Vital and Health Statistics*, 10 (99), May 1975.

This report presents statistics on the prevalence of impairments involving vision, hearing, speech, paralysis, absence of extremities, and orthopedic defects by type, site, and etiology. These impairment data are distributed by age, sex, color, family income, education of head of family, usual activity status, place of residence, geographic region, and associated chronic activity limitation. The estimates are based on data collected in the Health Interview Survey during 1971.

Wilson, Ronald W. and White, Elijah L. Changes in Morbidity, Disability and Utilization Differentials between the Poor and Non-Poor. Data from the Health Interview Survey 1964 and 1973. *Medical Care*, 15, 636-646, August 1977.

This paper looks at changes over the past ten years in the differences between the poor and the nonpoor in selected measures of morbidity, disability, and utilization of health services. Data are from the National Center for Health Statistics 1964 and 1973 Health Interview Survey. The review is organized into two sections. In the first section the authors consider classification systems that describe the general effects of illness or injury. In the second section they consider classification systems that describe the specific effects of long-term or chronic conditions. The data, presented by age and race, indicate that some of the gaps that existed in 1964 between the poor and the nonpoor have been narrowed or eliminated, particularly in terms of the utilization of hospitals and outpatient physicians. There is no evidence of marked changes between the poor and nonpoor in terms of dental care utilization.

Wilson, Ronald. Do Health Indicators Indicate Health? *American Journal of Public Health*, 71 (5), 461-463, May 1981.

A discussion of factors related to the inadequacy of health statistics in accurately representing health status. Shortcomings of traditional measures include: their insensitivity to the effects of medical intervention (which may result in a decrease of work days in order to insure future health), the effects of national disability programs and liberal retirement benefits on the loss of work days, and the use of return to work as an indication of successful treatment. Declining mortality rates may reflect the increased survival of disabled persons rather than an overall increase of health status. Functional ability may be a better assessment of health status than is disability.

Wilson, Ronald W. and Drury, Thomas F. Factors Affecting the Use of Limitation of Activity as a Health Status Measure. *Silver Anniversary of the National Health Survey Act*. Hyattsville, MD: National Center for Health Statistics, October 1981.

This paper discusses the conceptual and methodological factors that affect the interpretation of measurement of "limitation of activity," a major concept utilized in the National Health Interview Survey. Recent changes in questionnaire design, mortality patterns, disability benefits, and gender-related attitudes toward disability are considered in explaining the marked rise in reported disabilities. A brief comparison with other disability surveys is provided.

Wilson, Ronald W. and Drury, Thomas F. Interpreting Trends in Illness and Disability: Health Statistics and Health Status. *Annual Review of Public Health*, 5, 83-106, 1984.

An analysis of methodological and conceptual issues that must be addressed when using data from national sources such as the Health Interview Survey in order to determine health status. Factors to be considered include: survey examination methods, external factors bearing on the change of health reported statistics, and the appropriate interpretation of data. Trend analysis provides a more accurate means of assessing health status. For example, while there is a stable rate of hypertensives, there is an increase in self-awareness of hypertension and in the use of anti-hypertensive medication. Health indicators, illness trends and disability rates are each examined for problems and potentials in formulating estimates.



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